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EDITORS AND PROPRIETORS.

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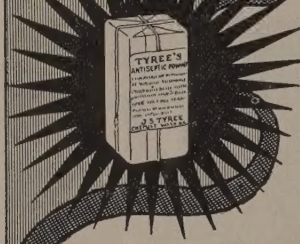


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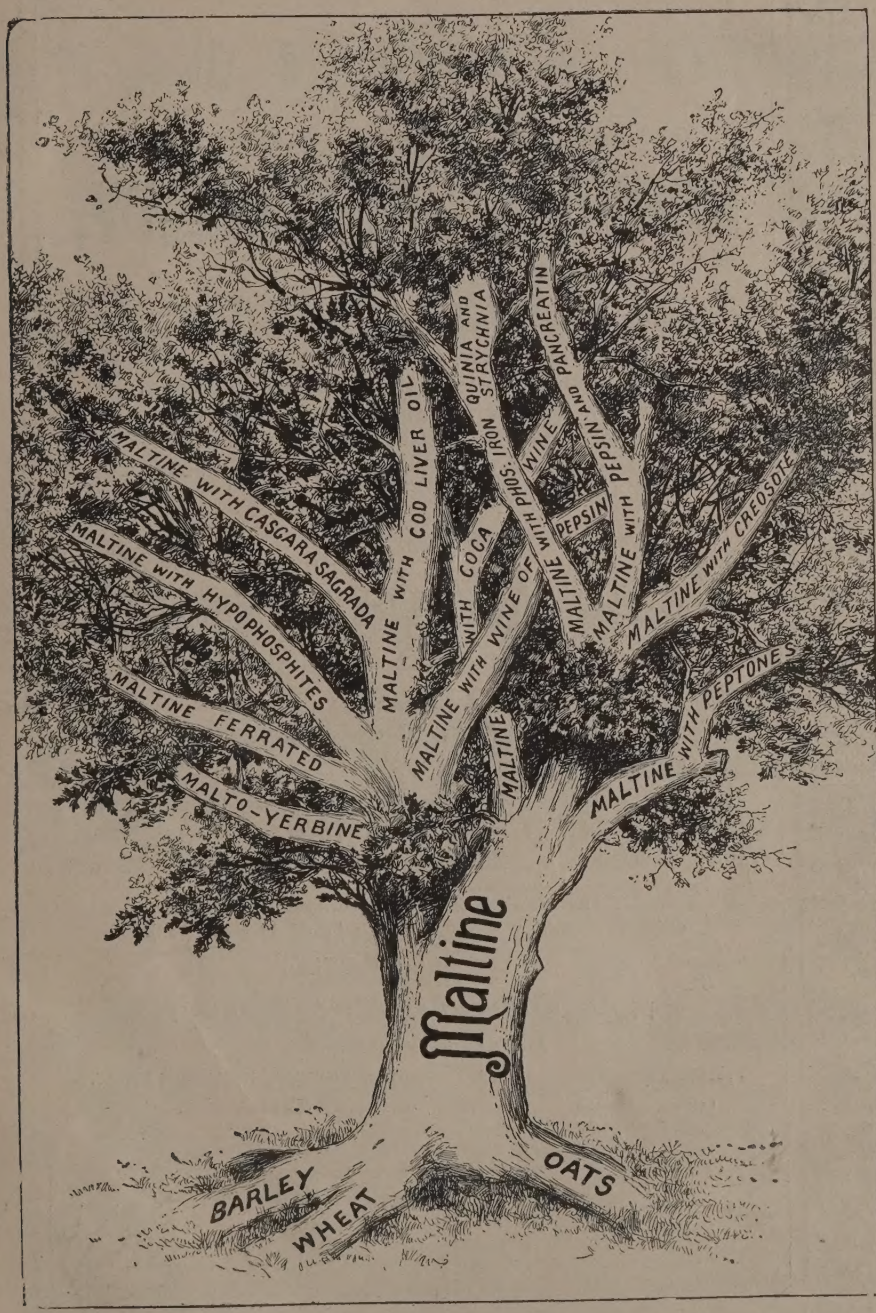
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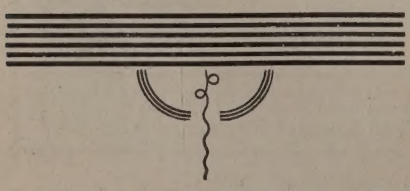

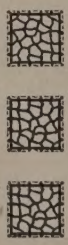

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An era is fast approaching, when no writer will be read and appreciated by the great majority, save and except those who can effect that for bales of manuscript, that the hydrostatic screw performs for bales of Cotton by condensing that matter into a period that before occupied a page.—COLTON.

## ORIGINAL COMMUNICATIONS.

### A PLEA FOR EARLY OPERATION IN OVARITIS FOLLOWED BY EPILEPTIFORM ATTACKS.*


BY W. HUTSON FORD, M.D.,

St. Louis.


Mrs. J. P., born in 1873, married in 1896. Her parents are healthy and well developed. The family consists of the father and mother and five children, three sons and two daughters. None of them, except our patient, has ever shown any tendency towards convulsive nervous attacks. I will mention, however, that in her last confinement, in which I attended her, the mother had an attack of hysterical convulsions, lasting a few minutes, soon after the delivery of the placenta. This was the only attack, which I attributed to the irritation of the cervix, which had been the seat of prolonged chronic inflammation. All the members of the family and the grandparents are, and have always been, very abstemious with regard to indulgence in wine or alcoholic liquids.

Our patient grew well from her birth, and was entirely free from nervous disease until May, 1887. She then had an attack of measles. Her attending physician warned her mother against the possibility of ovarian inflammation. After two weeks of measles, mumps supervened. When the mumps had lasted three or four days, the patient complained of constant pain, aggravated by pressure in the left ovarian region. A day or two after this, one morning, she had an epileptiform attack, specialized by loss of consciousness, distortion of the features, frothing at the mouth, etc. She had a second similar attack the same day, and again during the following night,

* Read before the St. Louis Obstetrical and Gynecological Society, Dec. 20, 1900.

and thenceforth every day, more or less often with the same symptoms.

The patient, who was now 13½ years of age, had not yet menstruated. In the following year one scanty period occurred, accompanied with increased pain in the right side. Menstruation continued scanty and irregular. The nervous attacks became more and more frequent, and as usual, more severe during the night, the tongue being sometimes bitten.

From this date, 1889, she was treated successively by a number of neurologists, all of excellent reputation, and some of national renown, both here and in other cities, palliation only being effected. The case was regarded as one of pure epilepsy, the attacks having been characteristically epileptiform from the outset.

During the next seven years, until her marriage, about four years ago, her condition continued very much the same, and she was married in accordance with the hope of some advisers, that marriage and child-bearing would effect a palliation or cure. This advice was erroneous: no such person should marry, for improvement does not ensue permanently, and the morbid state is apt to be transmitted to the offspring. She had long since declined any very active treatment, having realized that only mitigation of her symptoms could be effected by drugs.

I first saw her on Dec. 2, 1898. She told me that soon after her marriage she had become pregnant and that the attacks had ceased during five months, at the end of which period she had aborted. Soon afterwards the seizures reappeared and had continued as before, not very severe, and lasting only a few moments, more frequent at night than in the day. On the 19th of December I examined her and pronounced her pregnant again; she had missed the period in the November previous. I recognized, also, tenderness and fulness in the right ovarian region; she was then pregnant about six weeks. My advice was that she should go to term, and that I would endeavor to prevent the loss of the fetus by such medication as would mitigate the attacks. For a year or so the night seizures had been accompanied by spasm of the bladder, so that she was constantly wet. This did not happen during the day, as a rule, or but rarely. She occasionally bit her tongue at night.

A period of very distinct improvement, that is abatement, of the symptoms now ensued. Sometimes many nights, or even a week or two would pass without involuntary expulsion of urine. The attacks were fewer in number, and hardly involved any loss of consciousness; the tongue was not bitten. The treatment was by the bromides, ergot and gelsemium. Quinin, also, in 5 gr. doses repeated twice during an evening, seemed to be of advantage.

I delivered her of a well-grown female child on August 9, 1899. She had one attack by day during the labor. The child was perfectly formed, well developed and healthy. Up to this time, it has

shown no indication of abnormality in the nervous system. The mother suckled it at first and then reared it on condensed milk.

It was then agreed that as soon as her usual health had been regained, the mother should submit to a hysterectomy with removal of the ovaries. This course was adopted because, 1st, all other measures had failed; 2d, the maternal instinct had been gratified by the birth of a child; 3d, by the operation the possibility of more offspring was annulled; 4th, by the induction of an artificial menopause, the epileptiform seizures, always aggravated at the monthly period, would become milder; 5th, there was a bare chance, which I very plainly indicated as remote, however desirable, that by removal of the ovaries with the womb, a future cure was possible, while otherwise it certainly was not.

The family were determined to try the effect of such an operation, more desirous of it than I myself; I did not urge it, but consented.

On Nov. 22, '99, after a week's careful preparation in hospital, I removed the ovaries and uterus by the Clorobak method. The uterus was amputated at the level of the inner os. The peritoneum was very carefully stitched from one side of the pelvis to the other, covering in the stump of the uterus. The abdomen was closed by laminated suture, without provision for drainage. She made an ideal recovery, the temperature never passed 100.2, which is recorded for the third day, and fell to normal on the sixth. She left the hospital after three weeks, her convalescence having been wholly uneventful.

I herewith present the specimens; the left ovary is shown shrunken, but not diseased, apparently; the uterus normal; the right ovary a series of cysts, with almost complete destruction of the intervening ovarian tissue. This condition was recognized during the operation, but unfortunately, in the hands of an assistant the largest of these cysts, about the size of a small orange, was ruptured. It contained a clear fluid.

It is now about twelve months since our patient left the hospital. She had several slight seizures during the first week after operation, not, however, wetting the bed. After ten days, she had a more severe attack at night and wet the bed and bit her tongue. This occurred more than once during her stay at hospital. The day attacks were, however, so mild as to be scarcely perceptible, and she did not lose consciousness in any of them.

At this date, Dec. 13, 1900, her condition, reported to me by her friends, and in accordance with her statement to me in person, is as follows:

She still has marked menstrual flushes, lasting about four days, unaccompanied by any noticeable discharge whatever. For a few months after the operation there was a slight leucorrhea during the days corresponding, as they still do, to the epoch of her period, viz: from the 15th to the 20th of each month. These flushes are associated with fulness of the head and weight in the loins and pelvis. The frequency and intensity of the attacks are distinctly increased

at such times. The attacks occur both by day and by night. The day attacks are exceedingly mild; according to her statement, she never loses consciousness at all, and the attacks are only of a few seconds' duration, consisting merely of mental confusion. Nevertheless, she falls, as I have witnessed, and bruises or burns herself slightly. Her mental condition is quite good and her maternal instinct normal. Her daughter, now fourteen months old, is finely developed and has never shown any indication of a tendency toward nervous disease.

The night attacks now occur several times during the night; she states that they are very short, lasting only while one may count to six, but she loses a little urine at each of them, so that she is still kept wet at night. She has not bitten the tongue lately. Some weeks ago she had a stronger attack than usual in the daytime, and then a little urine escaped. But this was the only instance of the kind for a long period. She states that her genital instinct is very decidedly increased, and that its gratification seems in no way to affect either the frequency or intensity of the seizures.

Lately, after late driving, after which she drank beer, which she admits is injurious to her, she had for several days a series of seizures, and was confined to her room. This, however, passed off, and she is now in the condition above described. If she stoops to the floor, or assumes any posture in which the cerebral circulation is interfered with, she has a mild seizure; also, if she looks at any bright object attentively, attempts to read or sew. This reminds us of Charcot's researches.

Her diet, she states, is very plain, a little chicken or other white meat and vegetables. The bowels are disposed to constipation, and during her late attack, her brother, who is a medical man, informs me she voided a large quantity of scybala. The intestinal canal is well known to be the tract most distinctly the site of those peripheral excitements which act reflexively in the induction of many forms of convulsive attacks, and especially of those of an epileptiform character. Her late series of seizures were probably owing to indigestion and constipation.

There is, then, no distinct improvement in the state of our patient, creditable to the operation, except that the night attacks are milder, and that the bladder is not completely emptied at each of them. What the outlook of the case may be, cannot be now presumed; perhaps time enough has not passed since the operation. When all signs of a menstrual nisus have passed away and the artificial menopause is securely established, there may be a mitigation of her condition. But the reverse may also occur, unless her diet, sanitary surroundings and medication are carefully adapted to her case.

The operation has disclosed the fact that her right ovary has been in a state of cystic degeneration for a long period. More than twelve years elapsed since the attack of measles and mumps in which her first seizures, plainly epileptiform, occurred. She was perfectly well

before then, and has been a quasi-epileptic ever since. No one can doubt, I certainly do not, the direct causative influence of this ovaritis upon the nervous phenomena.

Hystero-epilepsy, a term which seems to have originated with Gowers, is epilepsy. I cannot see why the prefix "hystero," which indicates a relation to the uterus, is necessary or appropriate. In this case, the ovary was the source of irritation, perhaps both ovaries, and not the uterus at all. I would not designate the affection by the term oophoro- or ovarian-epilepsy. The disease was and is epileptiform from the beginning.

But does epilepsy exist in minor grades, and is it always dependent upon some form of irritation? Will the malady cease if this irritative cause be removed radically or surgically, or is the disease inherently incurable?

That seizures, at first irregular and slight, will ultimately become severe and frequent, so much so as to destroy the patient, mentally and bodily, is thoroughly well known. It is also the concensus of the profession that in many cases where there has been a local lesion or clear history, the surgical removal of the cause of irritation has been followed by a total cessation of the epileptiform seizures. The practice of trephining for the removal of clots, thickened dura mater, of spiculae of bone, or of depressed portions of the cranium, often enough quite successful, distinctly shows the possibility of a cessation of the seizures, if the primary source of irritation be removed; while if this is not done, the condition of the patient passes on into that of confirmed or inveterate epilepsy, new regional sites of irritation being produced in the brain and intestinal canal.

The seizures, now so well studied, which occur in males as dependent upon adhesive balanitis with sebaceous concretions and intense irritation in the sulcus preputials, are as plainly epileptiform in many cases as those described in the case of our patient. These forms of epilepsy are in no way curable by drugs, nothing but circumcision, complete ablation of the prepuce, will suffice. Whether this will completely cure every such case, or not, depends upon whether the epilepsy has affected the motor cerebral tract profoundly enough to establish a secondary reflexive area. That this occurs in time there can be no doubt, but as that condition cannot be affirmed accurately, there is always good reason for hoping that by operation the attacks may be annulled, if not immediately, at least ultimately, generally quite soon.

I have done a large number, for various forms of nervous disease, since 1876, when Sayre of New York directed the attention of the profession to these cases. Many of my cases were in young children, and the circumcision was always effective in arresting the spasm where other occurrence first called attention to the condition of the penis. In one case, particularly, a youth of thirteen, had been subject to severe epileptic seizures, I will not say epileptoid (for all this is epilepsy), from infancy. He had been treated all that time with

drugs, bromides especially. The condition persisted, and with each year became more severe; the loss of consciousness was complete and continued, as I saw in one of the spasms, for about five minutes. In company with his attending physician, I removed the prepuce. Although under anesthesia, the patient had a spasm during the operation, conclusively showing the fact that the chronic balanitis was the prime cause of operation, for the additional irritation of amputation was enough to precipitate a crisis. He got well, and had no other seizure, until about four weeks after. Having climbed a tree, the branch broke with him and he fell upon the sharp projections of the tree-box. His position and clothing prevented personal injury, but he had a spasm on the spot. This was in 1881 or 1882. Since then he has not had another. The mother called upon me a year afterwards to thank me for the operation, which had probably preserved her son's intellect.

That epilepsy is always at first due to the disturbance of the higher motor centres by some continuous peripheral irritation, is not to be doubted. It is even possible that the area of irritation may be cerebral, or at least intra-cranial, as Brown-Sequard emphatically affirms. Of course, in such cases, surgical intervention is hopeless, unless the offending tract be susceptible of removal. When the posterior columns of the cord are divided, as in Brown-Sequard's experiments on guinea-pigs, the young of such subjects are born epileptic. This very interesting determination shows that epilepsy may occur where there is no demonstrable initial lesion, but where only an undetermined abnormal condition of the nervous system exists. Such cases occur in the human subject, perhaps, undoubtedly; but their number is far less, in my opinion, than was supposed before the influence of peripheral lesions, especially of chronic inflammation of the genital apparatus in both sexes was distinctly admitted.

Even in animals, we have cases reported where distinct epileptic phenomena ensued upon some peripheral irritation, and were promptly abrogated upon the removal of this condition. At the meeting of the Societe de Biologie at Paris for Feb. 5, 1881, M. P. Meguin described a curious and instructive form of parasitic epilepsy in the dog. A number of dogs of varied breeds and coming from different sources, all belonging to one gentleman, were affected with a disease which caused epileptiform convulsions, and ultimately death after several months. These cases recurred during several years, and all the dogs bought to replace those that died became affected. Disinfection of the yard and kennel availed nothing. A terrier thus affected was carefully watched by M. Meguin for a week; he observed the epileptiform attacks and also the frenzied blows it constantly gave its ears. On examination, he found the external auditory meatus lined with a thick layer of cerumen, dotted with minute, almost imperceptible, white points, which, on microscopic examination, were found to be acari, of the species chorieptes caudatus. M. Meguin has been previously aware of the existence of this acarus in the auditory canal

of dogs, cats and ferrets only, and was aware that its presence could cause the frenzy of those animals, but had not observed the remarkable contagious character of the epileptiform affection. Repeated injection into the meatus of a 5 per cent solution of sulphide of potassium completely arrested the fits. (Lancet, May, 1881). Thus we see that an epilepsy, which plainly would have gone on to the ultimate destruction of the subject, was promptly and completely arrested by the abatement of the excitory local inflammation.

I must infer, then, from what has been set forth, that the only hopeful practice in epileptiform disease is removal of the offending causative irritation, medically or surgically. I have shown that this is thoroughly well understood and constantly practiced in an epilepsy of very varied origin, and has been for a considerable period of time. But in the special class of cases before us this point has not been distinctly seized, as of late many operations have been done for established epilepsy, hystero-epilepsy and menstrual mania, with no very satisfactory results as to cure. This only shows, in my opinion, that such operations have been deferred until the disorganization of the central nervous area and the establishment of secondary areas of irritation has been confirmed—in other words, too late.

As regards the propriety of operation in what we call hystero-epilepsy, the following citation may be of interest: Pozzi, p. 156, observes: "We shall see, in studying displacements of the uterus and diseases of the adnexa, that there are grave nervous troubles present at times, like chorea, epilepsy, etc., which depend directly upon them, and are curable at the same time."

"Lawson Tait has had encouraging results with ovariotomy in the cure of menstrul epilepsy. Yet G. Willers, a pupil of Hegar, has proved that there is more chance of cure if the ovary be diseased than if it be healthy. The same is true of hysteria and hystero-epilepsy with acute exacerbation at the menstrual period. Castration has given some good results; it has also resulted in many failures."

Pozzi states that beyond doubt removal of even healthy ovaries has often modified the condition of the nervous system so as to cause a disappearance of the grave reflex disturbances accompanying menstruation.

Pean prefers vaginal hystereoctomy to ovariotomy; he finds it more efficacious, even in overcoming the nervous troubles, than removal of the ovary. "In some exceptional cases," says Pozzi, "I have performed this operation and have obtained remarkable cures."

This affirmation constitutes an additional warrant for removal of the uterus; also, when the ovaries are excised in these cases.

Hermann (1898), p. 584, speaks of ovariotomy for the cure of epilepsy or insanity: "The experience of most persons who have spayed patients for so-called 'menstrual epilepsy' has been, so far as I can find out, unfavorable. The results of spaying the insane have

been, upon the whole, unfavorable; therefore I advise against spaying, either for epilepsy or insanity."

Howard Kelly expresses similar opinions. Here again we recognize the incurability of confirmed or inveterate epilepsy by operation.

Chauncey Palmer writes as follows in Keating's Clinical Gynecology, p. 807: "Unrelieved local pelvic disease, causing much pain, impairing usefulness and exciting hystero-epileptic attacks, may be combated by surgical means (after medicinal and hygienic measures have had a fair and continued trial) The gynecologic records of the last few years (1895) point unmistakably to the direct relationship, as cause and effect, of the two diseases, and prove that celiotomy performed as a dernier resort is not only justifiable, but necessary. But not every case so operated on has been bettered. Again and again have the attacks continued as bad as before. Past experiences warrant the following directions: Do not perform celiotomy for hystero-epilepsy unless unmistakable evidence of some structural or organic change can be detected within the pelvis. Be assured that this is the source of irritation, and that the nervous phenomena cannot be relieved by general medicinal and hygienic measures."

This is good advice, but capable of being easily abused by an unwarrantable and routine expectancy. I do not believe that much is ever to be expected but a progressive exaggeration of the symptoms, however abated for a time. While months roll by, under tentative use and partially palliative effects of belladonna, the bromides, arsenic and other drugs, and expensive changes of residence and foreign travel, the disease originated and maintained by the local condition continues to derange the nervous structure more and more, until all balance between the inhibitive and reflexive nervous areas is hopelessly lost. Any irritation will then cause a nervous explosion—either corporeal or mental. The genius of modern medicine looks askant at recommendations like this. Still some time must elapse before the practitioner is convinced of the exact nature of these attacks, and especially of their strict dependence, at the time, and originally upon disease of the ovaries. As soon as this is known, I hold that it is the correct practice to extirpate both ovaries and uterus, rather than wait for a cessation of the phenomena, which will not occur if they are founded upon organic pelvic disease, or the effect of drugs, for which nothing more than palliation has ever been claimed. I believe, then, the following conclusions are warrantable:

In cases of confirmed or inveterate epilepsy in females past the climacteric, do not operate.

In the same class of cases, not yet past the climacteric, operate if the disease is aggravated at the menstrual periods, and if any lesion or displacement, either of the uterus or ovaries, can be determined; otherwise, I should not recommend operation.

In the mild forms of what is known as hystero-epilepsy, if there is a history of ovarian or uterine disease, and if its existence can be

established by examination, and if annoying phenomena occur, like involuntary expulsion of urine, operate. Improvement may or may not occur if the case has run on for years and years under the employment of "medicinal and hygienic" measures, but at least the child-bearing functions will be abolished; the removal of pain accomplished; the focus of irritation brought to light and removed; danger of further disease of organs already diseased prevented, and the last chance of improvement or recovery given to the patient.

But still further, in cases where hystero-epileptic attacks occur during a recognizable ovaritis, as in the subject of our history, or after a latent or slowly developed ovaritis, what should be our practice? Should we continue by a routine administration of drugs from which we are perfectly aware but little is to be expected, or acknowledging that, "the gynecologic records of the past few years point unmistakably to the direct relationship" of the attacks and the pelvic disease, remove the internal organs of generation as soon as their diseased condition is established?

It is by no means in accord with the spirit of modern therapeutics to wait long in cases like these. Expectancy may be rational where there is doubt, but here there is often no room for doubt as to the original and continuous cause of the attacks, or with regard to the effect of drugs upon them. The knife should hang in imminence over these cases from the first, and should be brought into action as soon as the diseased condition of the pelvic organs is thoroughly established, and the absence of any other adequate cause or area of irritation determined. As long as the seat of irritation exists, the attacks will continue, and seldom, if ever, fail to become apparent in time.

In all cases of hystero-epilepsy marriage should be forbidden. The analogy between the phenomena of the sexual organs and those of epilepsy has been long since pointed out; the strain upon a weakened nervous organization is too severe, and cannot fail to interfere with the quiet and functional composure essential to a reductio ad integram of parts so delicately constructed, so liable to derangement and so closely in relation with all the organs.

In conclusion, I point to the attack of measles and mumps experienced by the patient in 1887; I point to the well-marked establishment of these hystero-epileptic, or if you will, simply epileptic attacks, then, even before the mumps had disappeared; I point to the diseased ovary, the seat of pain primarily and ever since, now before you, and for thirteen years acting as an irritant to the nervous system of our unfortunate patient; I point to a life wrecked by these conditions, and I ask whether it is indeed in accordance with the spirit of modern surgery that such an instance should be allowed to repeat itself.

# HEROIN HYDROCHLORIDE AS A REMEDY IN COUGHS.*

By W. E. FITCH. M.D.,
Savannah, Ga.

Heroin is the diacetyl-acid-ester of morphine and is a white crystaline powder without odor and a slightly bitter taste It is used in medicine principally for the purpose of quieting excessive cough. Unlike morphine, its effects on the respiratory centre is stimulant, rather than depressant, when it is given in medicinal doses. Under its influence the respirations are usually slightly slowed and deepened. The fact that it does not stupefy the patient, nor produce constipation is a strong point in its favor. Heroin is insoluble, therefore the hydrochloride of heroin is the preparation used for watery solutions; or heroin may be dissolved in water to which a little acetic acid has been added.

Heroin is morphine in which both hydrogen-hydroxyl atoms have been replaced by the acetyl radical $OC_1$ $CH_3$ thus forming the diacetyl-acid-ester of morphine. Heroin hydrochloride is a neutral salt which is very soluble in water (1:2); it is also white, crystaline, odorless powder like heroin.

Heroin may be administered in powder, pills or solutions. Experience with heroin would indicate that the initial dose should never exceed one-twelfth of a grain to a healthy adult, and in weak individuals, or the aged, an 1-18 or 1-24 grain would be a better dose. The hydrochloride of heroin is used in watery solutions, and when prompter effects are needed, than are afforded by the doses named above, the watery solution may be used hypodermically in 2 per cent. solutions in doses of 4 to 8 minims, a 1-12 to 1-6 of a grain three or four times daily.

Both heroin and its salt may be prescribed in combination with other drugs; as yet only one incompatibility has been pointed out, and that is, in combination with apomorphia, and it has been noted that the watery solution does not combine well with alkalies.

The physiological action of heroin hydrochloride has been aptly and concisely described as that of "a respiratory stimulant and a sedative to the respiratory mucus membrane." Its action in relieving cough and dysponea is prompt. Respiration is profoundly influenced in all cases; there is a decided dimunition in the frequency of respiratory movements, with a prolongation of the inspiration, and an increase of the force of expiration. The elimination of the secretions of the bronchial tubes is accelerated, aiding expectoration and relieving dysponea; there is no paralysis of the respiratory centres. The latter also reach less toward mechanical distention of the lungs after the administration of heroin. The circulation, after therapeutic doses, of the pulse becomes slightly diminished in frequency and likewise somewhat fuller. It produces no disturbance of the gastric functions. If long continued, a slight tendency to constipation may

* Read before the Savannah Medical Society.

be noted, but this can be avoided by combining cascara in your prescription.

Heroin hydrochloride is indicated in coughs of all kinds, whatsoever the cause, in dysponea, and in all catarrhal inflammation of the respiratory mucus membrane, and in all cases where morphine is contra-indicated. It is especially useful in pulmonary emphysema, the irritable coughs of grippe and in whooping cough, the drug is well borne and paroxysms are perceptibly shortened. In bronchial asthma it may be safely asserted that heroin hydrochloride is distinctly superior to any drug thus far used. A practical observer states "that what digitalis does for the heart, heroin does for the respiration." During attacks of asthma the drug may be used freely, since the somnolence which follows the larger doses is gladly welcomed by the patient and at the same time the patient feels the coincident respiratory stimulation. Some observers are agreed that in many cases of asthmatic emphysema the individual paroxysms are shortened in duration and the interval between the attacks distinctly lengthened.

In pulmonary phthisis, acute and chronic, heroin finds a large field of usefulness. It is superior to cocaine in most cases, and to morphine in many, and fulfils more indications than either of them, since it does more than simply allay the cough; stimulates respiration, removes the oppressive sensation of dysponea, promotes sleep, frequently lessens or prevents night sweats, and even at times reduces the evening rise of temperature.

The following are a few of the afflictions of the respiratory system where I have personally used heroin hydrochloride with entire satisfaction:

Case I. Baby S., aged 2 years. Diagnosis, whooping cough. The following prescription was given: Heroin hydrochloride, dilute sulphuric acid, tinct. belladonna and fld. ext. chestnut leaves. After the first few doses it was seen that this combination was very effective, for under its continued use the number and duration of paroxysms were perceptibly lessened, the symptoms at once improved, and while not curative, allows the disease to run a mild course.

Case II. Mrs. McC., aged 54 years, widow, family history markedly neurotic. Diagnosis, chronic emphysema, complicated with bronchial asthma. The patient is extremely nervous and suffers from frequent exacerbations, coming on apparently without cause. The cough was particularly distressing, patient sitting up in bed using all the muscles of respiration, trying to satisfy her hunger for air, the dysponea was profoundly noticeable, the skin livid, face anxious, pulse quick and feeble, mouth opened wide and gasping for breath. Auscultation revealed loud, sonorous and sibilant rales over both lungs. I at once ordered heroin hydrochloride, 1-12 gr., hypodermically and repeated this in 15 minutes. The effect was delightful, the dysponea became perceptibly less and less, the cir-

culation toned down and soon became restored and in a very short time patient presented a normal appearance. For the distressing cough I prescribed the following:

℞ Heroin Hydrochloride.....gr. iii.
Ext. Belladonna .....gr. vi.
Pulv. Ipecacuanha.. .....gr. xv.
Ext. Gentian..... .....qs. ft. pills.
No. xxxii. Sig. on pill every 2 hours.

Case III. Mr. C. C., aged 19, weight 110 pounds, referred to me by a colleague in another State. Diagnosis, pulmonary tuberculosis; duration of disease about 11 months. Patient complains of a hard persistent cough, worse at night, diminished expectoration, night sweats, insomnia, slight shortness of breath, fever, and gives history of pulmonary hemorrhage. Percussion reveals marked dullness over upper lobe of right lung, both anteriorly and posteriorly. On auscultation, increased vocal fermites and fine moist rales are found over area of dullness. He was put on heroin hydrochloride, gr. 1-6 three times daily, in combination with 5 gr. iodide potash, and in three days the cough was less marked and expectoration more abundant; by the seventh day the cough had ceased to give annoyance and sodium cacodylate, hypodermically, in 20 gtt. doses was commenced, and temperature soon became normal, the night sweats and dysponea disappeared. This case shows the great value of heroin in cases of pulmonary tuberculosis. Not only is its action in quieting cough and dysponea worthy of mention, but also its action in dissipating night sweats, and in this case large doses were used without dangerous results.

## MOVABLE KIDNEY.*

By R. L. PAYNE, M.D.,
300 Freemason St., Norfolk, Va.

My excuse for calling your attention to the subject of movable kidney is found in the fact that I frequently find patients suffering from this trouble in whom the real condition has been for years overlooked and who have taken widely varying medication without effect. This is due to the fact that movable kidney gives rise to several symptoms which are easily attributable to other causes and in the hurry of everyday work it is too often the case that we jump at conclusions and once having made a wrong diagnosis, it is strange with what fatuity we endeavor to maintain it. Again, the best trained physician often overlook movable kidney because he fails to make a proper physical examination, and I am fully persuaded no man should permit himself to prescribe for any abdominal disease until with the patient stripped and recumbent a careful examination of the whole abdomen is made. In no other way can we avoid frequent and

* Read before Seaboard Medical Society, Weldon, N. C., Dec. 13, 1900. Visiting Surgeon St. Vincent's Hospital.

mortifying mistakes. As I write I recall several cases of movable kidney that were mistaken for other maladies by usually competent physicians. Two of these were supposed to have had recurring attacks of appendicitis, another had been treated for intestinal indigestion, while still another had suffered many things of many physicians for some supposed liver trouble. Now, I wish distinctly to state that in each of these cases the diagnosis was comparatively easy and had not been made because of careless methods. Movable kidney is a not uncommon trouble and sometimes may exist without producing symptoms, but in a very large percentage of cases the patient suffers more or less and very many suffer at times attacks of excruciating pain. It is sometimes, but rarely, the result of traumatism causing a true dislocation of acute character, but usually the condition develops slowly, growing steadily worse as the years grow on. The trouble is more common in women than in men, and many observers believe that repeated pregnancies have much to do with its Etiology, this, however, I do not believe is true, because the majority of cases that I have seen have occurred in childless women and because the relaxed abdomen the result of repeated pregnancies is the factor which is alleged to play the most prominent role in this idea of causation, but he who has faithfully tried and seen how utterly futile is all external support in such cases cannot believe the support of the abdominal wall has much to do with the fixation of the kidney. The cases that I have seen have occurred generally in women who having been quite fat have grown lean from some exhausting disease, the fatty capsule is largely absorbed and the organ which is only loosely fixed at best, lacking this support the displacement readily begins and then the weight of the organ does the rest. Of course, added factors in the displacement under the given condition are found in tight corsets pressing other viscera down upon the now easily displaced organ. The right kidney is more frequently displaced than the left, and this fact is probably due to the pressure from above to which the organ is so easily subjected by reason of its position under the liver. The symptoms of movable kidney are vague pains in the abdomen and back, usually accompanied by greatly disturbed digestion. In some cases the pains occur in paroxysms and are very severe. The pains are sometimes referred to one point, sometimes to another, lumbar, hypochondriac or umbilical region most frequently, but in most of the cases I have seen there was nothing in the location of the pain to lead one to suspect any kidney trouble.

Only recently I have seen a patient with floating kidney, whose physicians had attributed all of her ills to a posterior and harmless displacement of the uterus. I had another case, the symptoms were so slight as to have attracted no attention whatever, while in still another the patient was bedridden and could not stand at all on her feet without suffering the most excruciating agony. Owing to the varying location and character of the pain the diagnosis is

often attended with more or less difficulty and can only be made by careful and oftimes repeated palpation of the abdominal contents when a smooth tumor, freely movable, and easily pushed back into the loin is determined. In thin subjects the shape of the kidney may sometimes be made out. The differentiation must be made between ovarian disease, tumors of the omentum; beginning enlargement or displacement of the spleen, renal colic and inflamed and distended gall-bladder. From ovarian disease movable kidney is usually easily diagnosed by the location of the pain and the complete relief to pain usually afforded by the recumbent posture; by the fact that the tumor can be easily displaced upward into the loin which cannot be done in ovarian tumor and the fact that in cases of ovarian tumor the vaginal examination reveals the presence of a tumor growing from within the pelvis. From beginning enlargement of the spleen if the tumor be on the left side, the diagnosis is made by the fixed character of the tumor in splenic enlargement and by the fact that the dullness on percussion elicited over the tumor is continuous with the area of splenic dullness, but if the spleen is enlarged and movable also then the diagnosis is more difficult and is to be based largely upon the relative size of the two organs and the the fact that wandering spleen does not give rise to paroxysmal pain. If, however, the spleen is atrophied and wandering, then the diagnosis is impossible, except in thin subjects with abdominal walls relaxed. From tumors of the omentum movable kidney may be diagnosed by the more fixed relations of the former and the fact that omental tumors cannot be pushed back into the loin. From renal colic the diagnosis is sometimes more difficult because in movable kidney the pain as in all kidney troubles is felt in the loin and may radiate down the groin and along the front of the thigh, but the diagnosis must be made by the presence of movable tumor and the complete relief of pain when with the patient recumbent the organ is pushed up into its proper position. In renal colic, blood may usually be found in the urine.

The diagnosis from inflamed and distended gall-bladder is often attended with great difficulty and this difficulty is much increased by the fact that the gall-bladder is sometimes movable as well as distended. Again, both organs may be very tender to palpation and both may be movable at the same time. The gall-bladder is usually more fixed in its relations than is movable kidney however and the diagnosis can usually be made by repeated careful examinations, though sometimes advantage must be taken of the relaxation of general anaesthesia and should we still fail, and the symptoms be grave, we may be forced to exploratory incision.

Puck declares "when doctors don't know they look in and see." Mayhaps we sometimes justify our reputation.

In the treatment of movable kidney, if any treatment be demanded, the only thing that offers relief is operation. I have seen several cases of more or less movable kidney which practically gave rise to

no symptoms and which demanded no treatment. If the diagnosis be made under such circumstances it is unwise to tell the patient anything of the condition. When one knows there is something not just right with any organ it is apt to set up a train of imaginary ills and this is especially true in the case of the abdominal organs. But there are many cases that cannot be ignored, the patient suffers from too great pain and is too prone to chronic invalidism to permit any dallying with the condition. All teachers seem agreed that many cases can be sufficiently relieved by wearing a proper abdominal bandage or a supporter, something after the order of a hernial truss, but I have yet to see any one obtain the slightest relief from any external support. Nothing will avail but an operation, having for its object the permanent fixation of the organ. After due preparation the patient is placed almost prone on the operating table and the ileo costal space on the affected side is made prominent by a thick pad under the abdomen. An incision is then made through the abdominal wall beginning one-half inch below the border of the twelfth rib and parallel to the rib until the retro-peritoneal space is opened. This incision must be of ample length and it must be remembered that the liver may be pushed down by the abdominal pad and due care be taken that it is not wounded or sutured. When the retro-peritoneal space is opened the kidney is brought into view by manual palpation and may require to be held by an assistant. At this point in the operation different operators vary the subsequent procedure. Some advise merely packing around the organ with gauze and then leaving the wound open, packing down upon the organ with gauze and trusting to the abundant granulation to fix the organ in place. Others suture the fibrous capsule of the kidney to the lumbar fasciae and then close the wound with suture. Others again suture in the same way but catch one or two sutures in the parenchyma of the kidney. The suture material must be of sterile silk or silk worm gut and both ends of the kidney must be sutured, else the organ will rotate on its long axis giving rise to pain and endangering the permanency of the operation. Others still split the fibrous capsule of the kidney, dissect out a portion of the capsule and then suture the organ with the freshened surface to the fascia, while recently it has been proposed that the fatty capsule be split freely, the free edges drawn out into the wound, several inches resected and then the edges of the resected fatty capsule be stitched in the incision and the incision closed. The advantage claimed for this latter method is that the kidney is not an absolutely fixed organ and if the slack in the relaxed capsule be removed the organ will be sufficiently and more naturally fixed than by any other procedure.

The two following cases illustrate methods I have used with success:

Mrs. S., AET 42, widow and mother of three children, was brought into my office on a chair supported by pillows. She was very much emaciated, was excessively weak; suffered constant indigestion and

complained of paroxysms of severe pain in the abdomen when she stood on her feet or took a step. She came to be treated for womb disease which did not exist, but I readily detected a very movable kidney. She was so very weak and run down that I kept her in bed a month while I attempted to build her up. Her pain was soon relieved by the recumbent posture, but would return as soon as she attempted to stand or walk. When sufficiently improved by rest, massage, etc., etc., operation was done. The usual lumbar incision was made and the organ brought into view. The fibrous capsule was split and the free edges stitched with silk to the lumbar fasciae. Iodoform gauze was packed down upon the exposed parenchyma and brought out of the lumbar wound. The wound was now sutured at either end, leaving the middle open where the gauze packing was brought out. The packing was renewed every second day until the wound healed from the bottom. The result was excellent. Soon after the operation the dyspeptic symptoms began to grow less, the patient began to take on fat and is now a strong, healthy woman.

Mrs. P., AET 32. Unipara gave the history of severe illness and rapid emaciation. Following recovery she began to suffer with pain in the lumbar region, radiating into the groin and down the front of the thigh. The paroxysms of pain were worse the more she was on her feet and were relieved by lying in bed. Her sufferings grew worse and worse until she became a confirmed invalid. Examination revealed a movable kidney on right side which readily came down to the umbilius and over to the median line auteriorly.

After due preparation the following operation was done. The usual incision was made, the organ exposed and sutured with silk to the lumbar fasciae. Two of the sutures passed superficially through the parenchyma of the kidney. The abdominal wound was closed at once and healed by first intention. The recovery was uninterrupted and the most gratifying results have followed the operation.

## RUNNING IN A RUT.*

By F. JULIAN CARROLL, M. D.,
Summerville, S. C.

*Mr. President and Gentlemen:*

While a student at that fine old institution which we are one and all proud to claim as our alma mater, I heard the popular professor of obstetrics, when called upon for a speech, assert that he would infinitely prefer delivering a twenty pound child to a twenty minutes' address.

Whether this preference on his part was due to the fact that his obstetrical deliveries net him a substantial fee, while addresses are as a rule non-remunerative, I am not prepared to say.

* Abstract of the annual address delivered before "The Association of the Alumni of the Medical College of the State of South Carolina," at its annual meeting in Charleston, S. C.

Personally, my experience with twenty pound babies and twenty minute addresses are equally limited, but I am inclined to think that they are both rather hard propositions to tackle, and in view of this inexperience of mine, I am rather puzzled to account for the origin of the compliment you have seen fit to bestow on me in selecting me as the annual orator.

I appreciate my thorough unworthiness of this distinction, as the soldier said when the cannon ball struck him, and I realize that I should have declined in favor of one more qualified for the task, but I have appreciated the honor too much to do so, and have resolved to tax your patience for a few moments by expounding my views on what can properly be called "Running in a Rut."

To the members of this honorable body whose practice takes them mostly over country roads—and I think the large majority of us have this misfortune—this phrase is more than a mere figure of speech. We know this rut full well, and while we daily anathematize it we must perforce use it. We also know that the more we use it the deeper it gets until finally it comes to be a case of rut or nothing.

Now, did we confine our running in a rut to our drives, our buggies and ourselves alone would be the sufferers. Unfortunately for our patients we do not. This practice permeates our daily life. As with our buggy wheels, so with our mental wheels—they make a track, which deepens into a rut, a rut that grows deeper and ever deeper till it becomes well nigh impossible to extricate ourselves from it.

I remember a story told me by a gentleman who had nursed extensively in Mississippi among yellow fever patients which I think illustrates very forcibly one of the ruts of the general practitioner.

It seems that there was an old physician of his acquaintance who had been treating yellow fever patients for forty long years, with one uniform result, the death of his patients.

Finally the old gentleman—the physician—decided to call in consultation a young Scotch doctor who had recently moved in the neighborhood and who had had some success in these cases. This was accordingly done.

"Now, doctor," said the old physician to the young, "I have noticed that all my patients leave me at a certain stage of the disease."

"And what stage is that?"

"The stage of remission."

"And what has it been your custom to give at that stage?"

"A large dose of castor oil and turpentine," answered the old man.

"Now doctor, suppose you omit the castor oil and turpentine in this case," suggested the young man.

The advice was taken in good part and the patient didn't get his dose. He got well and up to last accounts is not partial to castor oil and turpentine.

Now this old doctor had been running in the castor oil and turpentine rut for forty long years and had never seen any reason to

change. As long as his patients could stand it he could, and they never had any kick coming when he finished with them. The were beyond that, poor fellows.

Anyway, patients are poor judges of a physician's skill, or lack of it, and like all the rest of us they are themselves prone to running into a rut. If you are employed as their family physician they don't mind asserting openly that you are the only accident that ever happened, the only pill in the bottle, the only person that could play in their yard. Nothing in fact they can say can be too good for you.

But — — , just let them get down on you. Then your name is a particularly dark character of mud. One will pleasantly observe: "What, Dr. ——-! He couldn't cut the toenail of the left hind foot of my old yellow cur!" or "I always follow his buggy to know where the next funeral is going to be. He couldn't cure a ham." In fact, any old thing they can think mean of you they will multiply by 79 and tell it to the next scandal monger as a dead secret—then it circulates.

You are selected occasionally because of your ability, but most often because "mother and father" had you, or because Mrs. Brown across the way says you "done her tooth all the good," or perhaps you "spoke sweet" at the funeral of one of your recent victims, or maybe because Mrs. O'Hooligan has told your prospective patient: "An' shure Misthress Johnes he's a docthur as knows his business. Whin he says that a body's goun to doi thim moight as will sind fur th' praste, fur 'tis doi thim will, shure. Oi supphose he ought to' know; he knows what he guv thim."

Once taken into the family your retention becomes more a matter of tact than skill, as the following true story would tend to prove.

It seems that a physician—who of course is not a member of this Association—had been unusually proficient in piloting patients over those unknown waters to that "bourne from which no traveler ere returns." So successfully had he practiced this specialty of his in one large family of his clientele that only the husband and wife were left to mourn those who had gone before.

Now the good man of this household being rather fond of this wicked old world of ours and being little minded to exchange this "vale of tears" for the "happy hunting grounds" beyond the grave, determined to take thought as to the causation of the decimation of his family, lest he be the next victim.

After much pondering this good man by a process of exclusion came to the conclusion that their family physician had palpably been working more in the interest of the Undertakers' Union than of the Grocers' Union. Being a just man and little wont to discriminate he bethought him that the doctor's conduct had been unfair by the grocers, and straightway he determined to take counsel with his wife as to the advisability of getting a new physician.

He no sooner broached the matter to his good spouse than she flew out at him: "What! change my old physician who has been with me at the death bed of my seven children! No, sir, never!"

As married men we know that this argument was unanswerable, and the same physician attends this good family.

### RUTS WE RUN IN.

The ruts we, as medical men, run in are various and sundry and generally speaking they are the broadening out or the narrowing in of the ruts our preceptors traversed before us, just as we are broader or narrower than our preceptors.

Some of us in the early days of our practice conceived the idea that the more medicine we could pour down a given patient the better the patient's chances of recovery, and from that time on we have been filling our patients chock full of drugs and the grave yards chock full of patients. We remember that in our school days we have been asked: "Which weighs the most, a pound of lead or a pound of feathers?" The answer being the same, we have been using the pound of feathers in preference to the pound of lead. Quarts of decoctions and infusions when the alkaloidal extracts would have served a much better purpose and perhaps both of these when no drug at all would have been our proper cue. We have been running in a rut—a rut six inches deep with medicines.

Or perhaps we have blossomed out of college as a ready made specialist and gone to work on our specialty when we were incompetent to practice general medicine.

Say we have become a nose specialist. From year to year as our practice increases we see more and more noses until finally our entire view of humanity centres around a great big nose. In all diseases of mankind we see nothing but deviations of the septum, nasal spurs or enlarged turbinates. Behind and beneath all of this we know of nothing but hypertrophied tonsils and adenoid growths. We treat everything from ingrowing toenail to housemaid's knee, from apoplexy to cholera infantum, with the nasal douche or the tonsil-otome. We are looking at the world through its nasal organ and we are running in a rut.

Possibly, though, the eye is our specialty, adopted, we will say, in the early infancy of our medical career. Now we are out gunning for errors of refraction, and let the public beware. If a man falls down in an epileptic fit, Ranney like, we hasten to shove glasses on him before he recovers conciousness, and cure him—until the next fit comes along.

We are looking at the world through astigmatic glasses, and it won't be our fault if the world don't look back through the same medium. We have heard that the eyes are the "windows of the soul," and we are trying to get in at the window.

Maybe though neither the eyes nor the nose has it with us; we have adopted gynecology as our specialty. Now all our attention is centred around the female generative organs. We go on our way removing ovaries and wombs, sewing up perineii and cervices,

splicing uteri to the abdominal walls, and looking at the world through a vaginal speculum.

Any disease not the product of a derangement of one or all of the generative organs we do not understand and we do not believe to exist. We are like Hans Dinkenspeil. It seems that Hans on pleasure bent left his home in New York and took a trip to San Francisco. On arriving in this latter city almost the first person Hans met was his friend John Swineburger, also of New York. The surprise was mutual.

"Brigates Yon! What you in Zan Francico do?"

"Brigates Hans! I do de same as you; I wast on a wisit gome."

"Did you de Gape of Goot Hope around gome?"

"Nein."

"Did you de Panama Isthmus gross?"

"Nein."

"Did you de United States through gome?"

"Nein."

"Den you haf nod arrifed!"

"Oh yes, I haf. I de Dominion of Ganada through gome."

Unless diseases come through the channels we allot to them, like Hans we say: "You haf nod arrifed.

Unfortunately for our patients our assertion to that effect does not always relieve the situation. In short our rut is getting so deep that we can't see over its edges into our neighbors'—we are getting isolated.

Now, gentlemen, I want it distinctly understood that I am not hitting at specialists in particular. I am talking about narrowness wherever it be found, but I think that the tendency to make specialists to order and turn them loose before they are even competent to judge their "strong point," so to speak, in practice, is rather more calculated to engender narrowness than is general practice.

Speaking of peculiar adaptability, a young medical friend of mine, a country practitioner, recently applied for the marine hospital service. Asked what was his particular forte in practice, he answered, "surgery and the general practice of medicine." The presumption is that he considered himself a pretty good all around man.

Probably we, the "rutters," are doing good oftener than harm, but we are not doing all that we can and all that the public has a right to demand of us.

Gentlemen, the remedy for this is obvious. Let us run our ruts up against other ruts. In other words, let us come in contact with those who don't think as we do simply because we do. Let us of the solitary country roads run our rut into the populous thoroughfare. Then, and then only, will we come to the realization of the fact that ours is not the only wagon track on the highway.

Belong to medical societies, which represent the highway; subscribe to good medical journals, and do unto the editors thereof as you would have your patients do unto you, and when your assets

are enough ahead of your liabilities, or you can get ahead of your creditors, go North and take a post-graduate course.

Of course the personal equation must be considered, and it is possible that some of us are narrow enough and conceited enough to fail to derive benefit from our betters for the simple reason that we do not think our betters exist; these are beyond recall.

In conclusion, gentlemen, I realize that my twenty minutes' talk against narrowness is about as likely to prove effective as the old woman with the broom was likely to keep the sea back, and I trust you will excuse my monumental gall in making the attempt.

## ETIOLOGY OF CHRONIC EXUDATIVE NEPHRITIS.

By D. S. HANSON, M.D.,*

Consulting Obstetrician to the Cleveland City Hospital.

The Etiology of Chronic Exudative Nephritis, or as it is more commonly called, chronic parenchymatous nephritis, or large white kidney, is quite definite, all authorities that I have consulted agreeing.

It frequently follows an acute attack of renal inflammation, notably that of scarlet fever. Although in quite a large percentage it is insidious in its onset, uræmia or dropsy being the first indication of its existence, the patient being previously apparently in good health, more frequently, however, a more or less feeble condition of health is present for some time previous to the discovery of albuminuria. This form occurs more early in life as a rule than the interstitial or diffuse variety.

Any disease that overworks the kidneys, or irritates the epithelial covering of tubes and malpigian bodies, as repeated attacks of malaria, typhoid, pneumonia, etc., leaves a tendency to the development of this pathological process, for where patches of epithelia are repeatedly destroyed they are reproduced in a condition of lessened vitality.

Alcoholic excesses and excesses in eating are no doubt sometimes the cause, and it seems to me the intemperate use of food with an inactive or diseased liver is a most prolific source of this disease, the proteids being imperfectly converted, the epithelia of kidney is called upon to separate and eliminate uric acid and other irritants almost continuously, thereby destroying the vitality of these cells.

Syphilis and pulmonary consumption sometimes precede the development of this form of nephritis and probably have an etiological relation, and it is sometimes present in prolonged suppurating processes, although the amyloid kidney is more common here.

* In Cleveland Med. Gazette,

The acute parenchymatous nephritis of pregnancy is not infrequently followed by the chronic form of the disease, probably the general nervous irritablity incident to the pregnant state has a tendency to interfere with normal kidney secretion and render material carried to kidney more or less imperfect. There is also more work demanded of the renal glands, elimination having to be performed for both mother and fœtus. The nutrition of kidney is also interfered with, both by disturbance of general circulation and in later stages by direct pressure. It might truthfully be said that anything that interferes with proper digestion and nutrition, and especially any imperfect action of the liver, predisposes to this form of nephritis.

It is most common in young males. Much more often seen in temperate than in either torrid or frigid zones, and is not a very common disease.


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# Georgia Journal of Medicine and Surgery.

EDITED BY

St. J. B. GRAHAM, M. D. W. E. FITCH, M. D.

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All editorial communications should be addressed to St J. B. Graham, M. D., No. 6 West Liberty Street, Savannah, Ga.

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HALF-TONE ENGRAVINGS to illustrate accepted articles will be made free of charge, if proper drawings or negatives accompany the manuscript. Electrotypes of such cuts furnished at cost.

PHYSICIANS' WANTS, ETC.—A department will be devoted to the free publication of subscribers' wants, practices for sale, change of location, etc.

SECRETARIES OF MEDICAL SOCIETIES will do us a favor by keeping us informed of dates of meetings of same, etc.


## STOLEN HONORS.

Until a system is adopted by the medical profession for the filing of caveats and securing patents for original work, perpetuity of fame will ever rest upon an uncertain foundation. The name "Credé" has, beyond that of any other, been stamped deeply into the title of manual expression of the placenta for almost forty years. During this time, possibly, any patent would have expired. According to the Dublin Journal of Medicine and Surgery, June, 1900, there has appeared Mr. H. Jellert, who makes the following claim: (1) That the method of effecting the delivery of the placenta by external manipulations, as opposed to its manual removal or its delivery by traction of the funis, was originated in Dublin; (2) That Credé's method, when originated *de novo* in Germany, was identical in principle with the Dublin method, and that it came to assimilate itself to the Dublin method in its most important details; (3) That, consequently, there is no difference between the Dublin method and Credé's method, and that inasmuch as the method originated in Dublin many years before the time that Credé discovered it for himself, its name is and ought to be "the Dublin method."

The wide awake, enterprising New Englanders are not behind their Dublin brothers in claiming honors which should be generously conferred upon those who deserve them. Crawford W. Long, of Georgia, discovered and put into practical use anesthesia four years

before James Morton dreamed of anesthetics, and yet Morton gets the honor for discovering the greatest God-send in surgery. The late J. Marrion Simms, during the last years of his life, did more to restore this justly deserved honor to Long than any other man. By referring to the May issue, 1899, of this Journal, those who care to be informed as to the authenticity of Dr. Long's discovering anesthesia can read a symposium on this subject by four prominent Doctors of Georgia, who prove beyond doubt Long discovered anesthesia four years before Morton attempted to claim the honor of the discovery

Alas, this is the old story in medicine. How often is the saying of Bacon exemplified: "The small dog starts the hare and the big hound catches it." How often it has been shown that in medicine, as in commerce, it is the man who puts an invention to general use, who forces its introduction, and not the inventor, that receives both fame and royalties. It would, no doubt, be a kindly courtesy and a chivalric generosity to yield all possible credit to the obstetrical Dublinites of "many years before the time that Credé discovered it for himself," for it is long since Fame sat at their exigent banquet feasts. But would they long retain the laurel wreath upon their radiant brow?

We have not the means of historical research at hand in our present place of writing, but surely the Aborignees of our own western hemisphere could antedate the Dublin era had they but saved their wampum rolls; and as for the papyrus journals of ancient Egypt, beyond a doubt they hold in their hidden tombs complete descriptions, with illustrations, of manual expression of the placenta.

## THE GEORGIA MEDICAL ASSOCIATION.

The time for the Augusta meeting is only about four weeks off, and it behooves the different chairmen and secretaries of sections to put forth their best efforts to procure a good programme. The chairman of the committee on programme says a goodly number of papers have already been promised by the leading physicians of the State, as well as by prominent men from other States. The papers from intelligent country physicians, whose opportunities for observing certain interesting and important phenomena, not observed anywhere else, are most valuable. The State Association is a reunion, a swapping off of experiences, a rubbing up against each other to get new ideas. Don't excuse yourself by saying you are too busy. Say, Doctor, do you know it is only the busy men who attend medical society meetings? It is only busy and up to date men who prepare and read papers before medical society meetings.

Some of you doctors are like an old scythe which has hung up in the apple tree since last mowing time, you are rusty; it will do you good to go the Augusta meeting, rub up against your fellow practitioners and get the rust off and get on to new ideas and treatment

You will go back home better prepared for the alleviation of human suffering, to stamp out disease, and incidenally to earn an honest dollar.

Your clintele will think more of you for attending medical meetings: they know you will be benefitted by listening to papers, discussions, and experiences of other physicians. We trust each physician of the State will feel that he has been appointed to increase the attendance and membership of the State Medical Association and the Augusta meeting will excel any previous meeting held for years. Anyone who has attended two or three State meetings would not miss them without great sacrifice. You enjoy yourself, you get a rest, you learn medicine and surgery, you become broadened and liberal and better qualified for your life work.

## EDITORS' TABLE.

NOTICE.—SANDER & SONS' EUCALYPTOL.—Apply to Dr. Sander, Belle Plaine, Iowa, for gratis-supplied sample and literature on Sanders' Eucalyptol. Meyer Bros Drug Co., St. Louis, Mo., sole agents.

* *

The Stylus has been consolidated with the Interstate Medical Journal and the two publications continued under the latter name. Dr. William Porter, formerly editor of The Stylus, will be associated with Drs. W. B. Outten, R. B. H. Gradwohl and O. F. Ball, in the editorial management of the Interstate Medical Journal, St. Louis, Mo.

* *

American Medicine, the new weekly projected and promoted by Dr. George M. Gould, who was so forcibly and suddenly ejected from the Philadelphia Medical Journal a few weeks ago, will make its appearance either late in March or early in April at farthest. It has already taken solid financial footing, and it goes without saying that its editorial side with Dr. Gould at the head will be of the best. We have no doubt this new journalistic enterprise will prove an ornament to American periodical literature, as well as a profitable enterprise for its owners.

* *

The Maltine Company has distributed with its compliments a Physician's Visiting List, which is a pocket memorandum-book of great convenience. It is bound in black seal, flexible leather, is of convenient size, made of good paper, with gilt edges and rounded corners and is a ready reminder of the many excellent preparations made in the laboratories of this solid house.

New Orleans Polyclinic.—Physicians will find the Polyclinic an excellent means for posting themselves upon modern progress in all branches of medicine and surgery. The specialties are fully taught, particularly laboratory work. Fourteenth annual session opens November 12, 1900. For further information address Dr. Isadore Dyer, Secretary, New Orleans Polyclinic, New Orleans, La.

* *

Medical Examination Before Marriage.—A marriage license bill was introduced in the Wisconsin Senate January 16th, which promises to eclipse the marriage law of 1899. This bill provides that no persons can marry who are suffering from true or hereditary insanity, insanity caused by vicious habits or the use of drugs, consumption and various other diseases which are named in the bill. Every person who wishes to marry is required to go before an examining board of three surgeons to be appointed in each county of the State by the county Judge, and must pass an examination before a marriage license can be issued to them. In addition, all male candidates for matrimony who are under twenty-five years of age and all female candidates under eighteen years must produce a written consent of their parents before they can secure a license. Any clergyman, Justice of the Peace or other person who can perform marriages and who marries any couples who do not produce a certificate from the examining physicians of his county is to be fined not more than $500 or confined in prison not more than one year.

* *

Practice of Medicine as a Source of Income.—Dr. A. K. Steele, in Medical News, speaking of this all-important subject, says that there is a vast amount of ignorance on the part of the public, and of the profession as well, which is usually rudely dispelled when the dead doctor's will is made public in the Probate Court, and general surprise is expressed that Dr. A., who was reputed to have an income of from $20,000 to $30,000 a year, left his family only a ten- thousand-dollar estate, and had allowed his life insurance to lapse a few months before his death. The speaker said he had taken pains to ascertain the average income of doctors from their practice, and he is firmly convinced that professional incomes are greatly over-estimated. The expenses of the physician keep pace with his increasing business. Larger incomes demand better offices, a finer house, more servants, more social duties, and at the end of the year the balance sheet shows very little on the side of net profit. The two- to three-dollar visit, the five- to twenty-five-dollar consultation, the ten- to thirty-dollar case of obstetrics, and the larger fees provided for operative work in the fee table do not insure large incomes for many in the profession. The first five or ten years' practice is usually a struggle for existence; the second ten years' a competency, or good living, and during the third ten years the physician is likely to be crowded out by the younger and more progressive element. He said one

could count on the fingers of one hand the practitioners of Chicago whose incomes from practice exceeded $30,000 per annum, and probably not more than a score exceeded $20,000 per annum. The income of the average practitioner varies from $1,500 to $3,000 per annum. Office specialists—eye and ear, nose and throat—average $2,000 to $6,000; consulting physicians, $5,000 to $15,000; six leading physicians, $15,000 to $35,000; six leading surgeons, $20,000 to $60,000; six leading gynecologists, $10,000 to $20,000; six leading office specialists, $10,000 to $15,000; average surgeons, $3,000 to $10,000. One's income may be enhanced in a variety of ways, as, for example, increasing his reputation by original work; by essays and discussions in medical societies; by affiliation with medical colleges in a teaching capacity; by becoming attached to the staff of a reputable hospital; by caring for the sick or injured of a corporation; by making life-insurance examinations. It is perfectly legitimate to build up a practice in this way. Practice may be increased illegitimately by criminal curettements, by unnecessary operating, by useless visits, by exploiting cases in the public newspapers, by specialists' reprints for patients, by lending one's name to endorsement of proprietary remedies, etc.

* *

The Pneumatic Splint for Fractures.—We wish to call attention of our readers to a new device for treating fractures, originated by Dr. Hughes of Chicago. The apparatus is an adjustable pneumatic splint. This is something new and up to date in the treatment of fractures, through the use of which surgeons are in a position to fully employ and carry out all of the principles and desirable features pertaining to the treatment of fractures. Regarding the use of these pneumatic splints, Dr. John B. Murphy, Professor of Surgery at the Northwestern Medical College, and connected with nearly all the leading hospitals in Chicago, writes as follows: "I am using the pneumatic splints at the Alexian Brothers and Emergency Hospitals, mostly in fractures of the femur, and in those of the leg results were perfectly satisfactory in all cases. The conditions are admirably adapted to the purpose for which they are intended, and extension and counter-extension are easily carried out with the splints. I use them successfully in the ambulatory treatment of fractures and convalescents from fractures." When a surgeon of Dr. Murphy's ability says a thing is good, it is good. Watch our pages for advertisement of this new splint.

## NEW BOOKS.

FROM W. B. SAUNDERS & CO.

**The Treatment of Fractures**—By Chas. L. Scudder, M.D., Assistant in Clinical and Operative Surgery, Harvard Medical School. Second edition, revised and enlarged. Octavo, 433 pages, with nearly 600 original illustrations. Philadelphia and London, W. B. Saunders & Co., 1901. Polished Buckram, $4.50 net.

The exhaustion in a remarkably short time of a large first edition indicates the favor with which this work has been received. From the day of its issue it has been accorded the highest possible praise, as being the most practical and useful work on the treatment of fractures that has ever been issued. In this edition the book has been thoroughly revised. Many X-ray plates have been reproduced to assist in familiarizing the reader with the study of such plates. Physicians should be able to interpret X-ray plates without the assistance of an expert. Numerous other new illustrations have been added, and the book has been considerably enlarged.

This book is intended to serve as a guide to the practitioner and student in the treatment of fractures of bones. The author endeavors to divert the reader's attention from theories and apparatus, to actual conditions that exist in the fractured bone, encouraging him to determine how to meet the conditions found in each individual case of fracture. The author omits a few very special fractures and in all cases advises mechanical simplicity, splints of special manufacture are not described, as their description would distract attention from the fracture. The terms "simple" and "compound" fractures are not used, but instead expressions *closed* and *open* take their place, the author claiming that the latter expresses express definite conditions. So far as possible many of the details in the treatment of fractures are illustrated, so also will be found types of dressings for special fractures are described. Tracings from the Röntgen Rays are very liberally used throughout the work to illustrate the sites and displacement of fractures.

This is a very practical work and worthy of commendation, a valuable contribution to surgical science. Mr. Saunders gets it out in good style.

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**Diseases of the Nose and Throat**—By D. Braden Kyle, M.D., Clinical Professor of Laryngology and Rhinology, Jefferson Medical College, Philadelphia; Consulting Laryngologist, Rhinologist and Otologist, St. Agnes' Hospital. Second Edition, revised. Octavo, 646 pages; over 150 illustrations and 6 lithographic plates. Philadelphia and London, W. B. Saunders and Co., 1901. Cloth, $4.00 net.

The first edition of this work was exhausted in less than a year. The author has accordingly taken the opportunity of thoroughly re-

vising the book and bringing the subject matter absolutely down to date. The work presents the subject of diseases of the nose and throat in as concise a maner as is consistent with clearness, keeping in mind the needs of the student and general practitioner as well as those of the specialist. One of the special features of the work is Dr. Kyle's logical classification of diseases, the modern pathology illustrated with new and original cuts, and the extended consideration given to the details of treatment.

The author very wisely gives considerable space to certain diseases which are somewhat rare, with the idea that when information is desired upon a subject it should be full and complete, We regret to see that Dr. Kyle omits the reports of individual cases, which are an attraction to most works on this subject. The work contains 23 chapters and covers very thoroughly all diseases of the throat. The illustrations are particularly fine, being chiefly original. With the practical purpose of the book in mind, extended consideration has been given to details of treatment, each disease being considered in full, and definite courses being laid down to meet special conditions and symptoms.

Such a book as the one before us shows how plain and attractive a subject can be made by an author who thoroughly understands it himself and who has constant practical dealings with it. We know of no book in the specialty of the diseases of the eye, ear, nose and throat and their accessory cavities that more satisfactorily simplifies the diagnosis and treatment. The work before us is a most excellent one, magnificently illustrated, and well adapted to accomplish the end the author had in view. It displays thought and care in preparation, and from the author's conservative tendencies should have a good influence upon the student as well as the physician who adds it to his library.

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FROM J. B. LIPPINCOTT CO.

**A Treatise on Appendicitis**—By George Ryerson Fowler, M. D., Professor of Surgery in the N. Y. Polyclinic; Examiner in Surgery, Medical Examining Board of the Regents of the University of the State of New York; Surgeon to the Methodist Episcopal Hospital; Surgeon-in-Chief to the Brooklyn Hospital; Consulting Surgeon to St. Mary's, The Relief, and the Norwegian Hospitals, etc. Second Edition, revised and enlarged. 235 pages, 58 illustrations, 13 plates, 5 colored. Cloth, $2.50. J. B. Lippincott Co., Philadelphia, London and Montreal, Dec., 1900.

The first edition of this work was a revision of a series of articles which appeared in the Annals of Surgery, under the title of "Observations on Appendicitis." The first edition having been so favorably received, and the increase in professional interest making the second edition necessary so soon, speaks well for the work. In this revision Dr. Fowler has entirely rewritten many chapters, many have

been recast to bring them up with the present advances in surgical science, two new chapters have been added, one on the "Differential Diagnosis of Appendicitis." This is a timely chapter, for many physicians of acknowledged ability and repute sometimes err in their diagnosis. The author in this chapter has endeavored to systematise all the available knowledge of lesions likely to be mistaken for appendicitis, so as to assist the practitioner in arriving at a conclusion in doubtful cases at an early stage of the disease. The other new chapter is devoted to "The Non-operative Treatment of Appendicitis." The author recognizes that some cases of appendicitis must, of necessity, receive non-operative treatment at some stage of the disease, and in cases where the patient, or those who are responsible for him, refuse operative treatment, this chapter contains a concise view of the medical treatment of appendicitis.

In this revision the author drops some of the older methods of operations, which have been abandoned, and reviews the new ones added. The operative procedures are fully outlined and made clearer by many excellent drawings from nature, and thirteen full-page plates, many of which are in colors.

This is the best exposition of the subject under consideration it has been our pleasure to examine. It is written in a clear, concise, practical style, so interesting that you want to read the whole book before laying it aside. It is a book every physician should read.

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**Diseases of the Nervous System.** A Text-book for Students and Practitioners of Medicine. By H. Oppenheim, Professor at the University of Berlin. Translated by Edward E. Mayer, M. D. Pittsburg, from the second revised and enlarged German edition. Philadelphia and London: J. B. Lippincott Company.

The two most important books on diseases of the nervous system that have appeared in recent years are Gowers' classical and well-known work and Oppenheim's text-book, which Mayer has made accessible to the English-reading public by his careful translation. The translation is both accurate and readable. The illustrations are well and faithfully reproduced. The book may be called a personal one, for it reflects the author's teachings and beliefs, but it is in no sense narrow. Of all the text-books on nervous diseases it is the best one to be placed in the hands of the medical student.

The author's chief aim in presenting this subject before the profession was to make the book useful to practitioners, therefore he has seen fit to lay marked stress upon symptomotology, diagnosis and treatment, and devotes only sufficient space to pathological anatomy to shed the proper light upon the course of a disease, or to pave the way for a diagnosis; the anatomy and physiology of the nervous system in a concise yet complete manner, and this elucidation is enriched by appropriate plates. In Part I, General, the author describes the "methods of examination," "general symptomatology" and "objective examination;" the student is told how the

examination of a case should be made. In Special Part II Section I, the author describes the diseases of the spinal cord; Section II, diseases of the peripheral nerves; Section III, diseases of the brain; Section IV, the neuroses; Section V, disease of the sympathetic nervous system; angioneuroses and trophoneuroses, and in Section VI, toxic conditions, with predominating nervous symptoms.

Oppenheim's thorough knowledge of the histology and pathology of the nervous system has given him a just appreciation of the relative value of these subjects, and the extent to which a discussion of them should be carried in a text book. The book is of great value to the general practitioner. The author's references to the treatment of cases of nervous disease are both practical and rational.

Messrs. J. B. Lippincott Company recognize the merits of the work and turn it out in good style, elegant binding.

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FROM F. A. DAVIS & CO.

**Sajous' Annual and Analytical Cyclopedia of Practical Medicine.**—By Chas. E. de M. Sajous, M. D., and One Hundred Associate Editors, assisted by Collaborators and Corresponding Editors; Illustrated with Chromos, Lithographs, Engravings and Maps. Vol. VI, Rectum and Anus, Diseases of, to Zinc. Subscription to entire series only. Six volumes: one every six months. Cloth, $5.00; Half Russia, $6.00. Monthly supplements sent free during three years. Philadelphia, Pa.: F. A. Davis & Co., Publishers, 1914 Cherry St.

The sixth and last volume of this most excellent work has just reached our review table, and, from a critic's standpoint, we can only praise the work. This volume is in keeping with its predecessors both in subject matter, workmanship and elegance. The subject-matter begins with "Rectum and Anus, Diseases of," and covers, alphabetically, all medical and surgical subjects to and including "Zinc."

There are to be found in this volume many interesting and valuable contributions, by men who have international reputations. Each chapter is written by a man who is a master of the subject for discussion, and in addition to his own ideas on the subject will be found excerpts representing the cream of the most recent contributions to medical literature. It is impossible in a short review to speak of all the excellent features of the volume.

Among the subjects especially worthy of mention we ask our readers' attention to the article from the pen of Dr. F. Levison of Copenhagen, on "Rheumatism; Acute, Chronic and Gonorrhoeal," which is a paper of great value; and the article of Dr. R. H. Sayre of New York, on "Spinal Cord, Diseases of." We derived much information from this chapter. Next we notice "Stomach and Intestines, Surgery and Diseases of," by Dr. C. S. Witherstine of Philadelphia, and "Strychnine Poisoning," by the same author. Among

articles of special value we cannot refrain from mentioning "Syphilis," by G. Frank Lydston, M. D., of Chicago. This chapter is written in Lydston's easy, entertaining style, and is full of practical points; and next we note the subject of "Tuberculosis," by J. Edward Stubbens, M. D., and J. D. Richards, M. D., of Loomis Sanitarium, Liberty, N. Y. The reviewer is familiar with the methods of treatment in this institution, having visited there during the past summer.

Dr. James E. Graham of Toronto Canada, writes a very practical and instructive paper on "Typhoid Fever," treatment and general management of cases.

J. William White, M. D., and Alford C. Wood, M. D., of Phila., tell you about all you will ever want to know about the diseases of the urinary system, and general treatment—both medical and surgical; and next, Dr. Walter Wyman, Surgeon General U. S. M. H. Service, discusses "Yellow Fever, Etiology and Pathology of; Treatment and Management of Epidemics." Dr. Wyman is in a position to speak authoritatively on the subject, having had a wide field of experience with the fatal "Yellow Jack," the paper is of great value to the profession.

A pleasing feature of the work are the Journal references given at the end of each abstract. The author's views are in regular size type, with abstracts in small-pica, thereby facilitating study if you wish to refer to a subject for reference, you can find them without trouble.

This is an invaluable work and contains a resume of all that is of any importance which has transpired during the past decade in medical, surgical or allied sciences. It is a valuable acquisition to any physician's library, not only for those who write and must therefore keep up, but also those who treat disease, for everything new and of value is at your finger-ends, so to speak.

Messrs. F. A. Davis & Co., realizing its genuine worth, turn it from the press bound, handsomely printed on good paper, with strong cloth binding, with all the art and attention to detail in medcal book publishing from which they are justly famous—and it gives the reviewer pleasure to recommend the Annual.

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**Infant Feeding in its Relation to Health and Disease**, by Louis Fischer, M. D., Professor of Diseases of Children in the N. Y. School of Clinical Medicine, formerly Instructor in Diseases of Children in the N. Y. Post-graduate School and Hospital, etc., containing 350 pages and 52 illustrations, with 23 charts and tables, most of which are original. The F. A. Davis Co., 1914 Cherry Street, Philadelphia. 1901.

During the author's 10 years experience as a teacher in the largest children's clinic in this country he has had ample opportunity to study the intricate problems in infant feeding. While lecturing on diseases of children at the N. Y. Post-graduate and N. Y. School of Clinical Medicine, the author noted the great anxiety with

which his classes, all of whom were active practitioners, requested detailed information regarding the modern methods of infant feeding, and from such requests the author was lead to believe that a text-book combining his experience with valuable suggestions from the various text books; giving detailed information pertaining to the feeding of infants and children requiring breast-fed or hand feeding, would serve as a guide to the general practicioner, and the profession are under obligations to Dr. Fischer for the best work we have ever examined on this momentous subject.

Part I is devoted to the anatomy and physiology of the infantile stomach; digestive ferments: their action, fermentation and absorption constituents; variations of milk; breast feeding; wet nursing; raw cow's milk; modified milk; bottle and table feeding; sterilization and Pasturization of milk.

Part II contains information on incubator feeding; the various infant foods; condensed milk forced feeding; infant stools; colic; constipation; rachitis; dentition; marasmus, and general rules for infant feeding. Taken altogether it is a very practical exposition of the subject and a book every doctor who has the care of this class of patients ought to read.

FROM THE HENNEBURY CO.

**Hypnotism**—By L. W. DeLaurence, instructor at the School of Hypnotism and Suggestive Therapeutics, Pittsburg; 256 pages, cloth binding; price, $11.50. The Hennebury Co., 415 Dearborn Street, Chicago.

This is the second edition of Prof. DeLaurence's work on Hypnotism, the first was reviewed by us in August and a call for the second edition so soon speaks for its popularity. The book is written by a professional Hypnotist and is meant more for the laity than for scientific students of medicine. To those unacquainted with methods of Hypnotism the book would prove a value as leading up to a more scientific study of the subject.

This office has for sale CHEAP tickets for Post-Graduate course in the New York School of Clinical Medicine. Write the Editors.

# PROGRESS
—OF—
# MEDICAL SCIENCE.

## THERAPEUTICS

UNDER THE MANAGEMENT OF
RALSTON LATTIMORE, M. D.,
SAVANNAH, GA

THE TREATMENT OF THE PAROXYSMAL STAGE OF WHOOPING COUGH.—The British Medical Journal of November 9, 1900, has in it an article by Godson, in which he reminds us that the following drugs have been mentioned as of service in the treatment of this disease: Alum, antipyrin, acetanilid, belladonna, bromide, cannabis indica, carbolic acid, chloral hydrate, creosote, lobelia, opium and its derivatives, phenacetin, quinin, etc.

This list, on account of its prodigality, is confusing to the novice, and appears to show that there is a considerable difference of opinion with regard to correct treatment of pertussis.

Inhalants appear to be in general use, the ones referred to being carbolic acid, creosote, bromoform and chloroform.

The method of treatment Dr. Godson has found most satisfactory is the following: Commence at once with the continuous inhalation of creosote.

Clear the lungs of bronchitis as much as possible before using any special internal antispasmodic remedies. In bronchopneumonia, however, belladonna appears at once to do good. In all cases, if the chest is fairly clear, and the circulation good, antipyrin may be given in suitable doses. Expectorants should be combined with the antipyrin. Good air, warm clothing, light and wholesome food are necessary in all cases. He has followed these rules for the last six years, and is quite satisfied with the results. The average length of time required for cure in a variety of cases last year was 19 8 days, but these figures in no way represent the benefit derived from the creosote treatment. In every case the diminution in the number of paroxysms was so immediate that the patient willingly put up with the inconvenience of the smell of the drug for the sake of its manifest advantage. This in itself is a sufficient testimonial to the remedy to warrant its more extensive employment.—*Therapeutic Gazette.*

THE USE OF THE SUPRARENAL CAPSULE IN THE DISEASES OF THE LOWER AIR-PASSAGE; A PRELIMINARY REPORT.—In the Medical Record of November 17, 1900, Floersheim reaches the following conclusions:

1. Indications for suprarenal powder: The suprarenal powder is indicated in acute and chronic bronchitis, bronchiectasis, asthma,

congestion and edema of the lungs, hemoptysis, and in some cases of pulmonary tuberculoses, especially in those associated with hemoptysis.

2. Method of administration: The suprarenal powder was administered in the form of three-grain capsules on account of their convenience. The powder is to be chewed without water and then to be swallowed in a few moments.

3. Rapidity of the action of suprarenal powder: The action becomes apparent in from two to fifteen minutes.

4. Permanence of the action of suprarenal powder: In some cases the action of the suprarenal powder was permanent, while in the majority of cases the action was temporary, continuing from ten minutes to six hours.—*Therapeutic Gazette.*

Copper Poisoning.—Dr. H. A. Kurth, Medical Record, says: Until the last twenty or thirty years, copper poisoning was not at all common. But with the enormous growth of manufactures in the United States these cases have become so numerous that any physician in a manufacturing city is likely to meet them. The symptoms are as follows: "The face, in advanced cases, has a drawn, anxious expression as in marked phthisis. Anemia is found in all cases. The effect of this upon the complexion is different from that of other anemias. To me it appears several shades darker. The term sallow comes close to describing it. I know of no class of men who can be so intensely nervous as copper workers. Their restlessness is without limit. In their homes they are irritable and excitable. Sleeplessness is, of course, common. Itching and neuralgic pains in different parts of the body are here and there complained of. Emaciation is typical of the disease. One author calls them a 'spare, unhealthy set of men.' The emaciation is not confined to the muscular tissue. Loss of strength naturally follows such emaciation.

"The symptoms that are of the greatest value in the recognition of cases of copper poisoning are: 1, dyspepsia, which is the earliest of all symptoms; 2, anemia, which also is early and comes before emaciation, loss of strength, or painful facial expression; 3, nervousness and irritability. Add to these the facts that the patient works in copper or brass, and you can not be mistaken."

Alcohol as an Antidote to Carbolic Acid.—Dr. Herman A. Klein (Jour. Amer. Med. Assoc., xxxv, p. 1557) corroborates by some personal experiences the statements of other writers as to the efficiency of alcohol in carbolic-acid poisoning. About 2 oz. of carbolic acid had been thrown into the face and hands of a woman. He arrived about fifteen minutes after the occurrence, and bathed the parts freely with alcohol for about half an hour. Marked improvement took place at once; pain was diminished, and the skin assumed a healthier color; later, carron oil was applied. In about a week the patient was perfectly well, without a mark on her face. In another instance a woman drank 2 oz. of carbolic acid. She

was seen ten minutes later by the writer, who administered 4 oz. of alcohol every half hour for three doses, then 1 oz. every hour for four doses. He also administered $\frac{1}{4}$ gr. of morphine hypodermically, and repeated the injection in two hours. The patient was discharged well in six days.

The third case illustrates the value of carbolic acid and alcohol in surgical practice. A man received a serious injury in the arm, and it became infected. Carbolic acid—95 per cent.—was applied to the infected wound for a minute at a time, followed by alcohol. After four applications the infection disappeared, the patient making an uneventful recovery.—*Merck's Archives.*

Toxic Action of Sodium Cacodylate.—Dr. Wm. Murrell (Brit. Med. Jour., No. 2086) warns against the careless and indiscriminate use of sodium cacodylate, stating that the claim that it is absolutely innocuous even in large doses is not borne out by the facts, as a case under his care well illustrates. The patient was a young woman suffering from moderately advanced phthisis. He ordered 1 gr. of the drug in pill form three times a day. The sodium cacodylate was carefully selected and obtained from a well-known manufacturer in Paris. After taking eleven pills the patient suddenly developed symptoms of arsenical poisoning. She suffered from constant nausea and vomiting; there was complete anorexia, the tongue was raw and irritated, the conjunctivæ inflamed and the eyelids edematous. The breath had a gangrenous odor, there was tenderness and deep pressure along the course of the nerves, and the patient was unable to move the left leg or extend the left wrist. On suspending the treatment the acute symptoms subsided in twenty-four hours, but the loss of power in the leg and wrist persisted for three days. Of course it is possible, the author states, that his patient was particularly susceptible; but, anyhow, if he ever prescribes sodium cacodylate again, it will be in much smaller doses than those recommended by the French physicians.—*Merck's Archives.*

Ichthyol in Smallpox.—Dr. M. Kamneff (Therap. Monatsh., Dec., 1900, p. 682) reports having used ichthyol in the treatment of a number of cases of smallpox with most excellent results. He applied the drug in the form of a 12 to 20 per cent. ointment. From the very first day of treatment there is a marked amelioration of all symptoms. The duration of the disease is shortened, and, what is most important, no marks are left on the face or elsewhere.—*Merck's Archives.*

Ichthargan in Acute and Chronic Gonorrhea.—Dr. Lohnstein (Med. Rev. of Rev., 1900, p. 951) gives an account of this new remedy, with special reference to its employment in gonorrhea. Ichthargan possesses a special interest, because it combines the properties of two valuable medicinal substances, ichthyol and sil-

ver. In theory, such a combination ought to possess great antibactericidal properties, and the recently-made experiments of Aufrecht show that this supposition is correct.

In regard to its clinical application, Leistikow has been using ichthargan for a year, and reports the best results in recent gonorrhea. The strength of solution employed varied from 1-50th per cent. to 1-5th per cent. Injections of this solution were begun at the very first of the attack. The usual balsamics were given inwardly.

Ichthargan is a brown, amorphous powder, with an odor resembling that of chocolate. The act of smelling this substance causes violent sneezing. The amount of silver in ichthargan is 30 per cent., the metal existing in combination with organic, strongly sulphurized substances, which are derived from the ichthyol sulpho-acids. Ichthargan is readily soluble in water, glycerin, dilute alcohol, ether, and chloroform. A concentrated solution is precipitated by solutions of salt and of albumin.

The author has thus far applied this remedy in 187 cases of gonorrhea, of which number 124 were acute, and 31 of the latter primary cases. Of these 31 cases, 24 were cured by ichthargan *alone*. Four would not yield to the new remedy, and were treated otherwise, while the remaining three gave up the treatment prematurely.

The author applied the solution in the form of a douche. The urethra having been cocainized, a soft catheter was introduced, and a warm, weak solution was allowed to enter by gravity from a moderate height. This management was not provocative of any unpleasant accidents. Out of the 187 cases of gonorrhea treated by irrigation, there was only one complication of epididymitis. The irrigation strength of the ichthargan solution was 1:4,000 or 1:5,000. This strength could be increased to 1:2,000 in select cases. Of the 24 cases which recovered, 10 were cured in from two to three weeks, while the other 14 required from three to six weeks.

Can Pneumonia Be Aborted?—Kr. J. Paffrath (Deut. med. Zeit., No. 42, 1900) thinks that it can. His remedy consists in a combination of antifebrin and Dover's powder, which he administers every three or four hours, day and night, until the temperature becomes nearly normal. The doses of the drugs for each powder are: Antifebrin, 6 to 8 gr.; Dover's powder, 4 to 5 gr. The powders are interrupted when the temperature falls to 100.4° F., to be resumed when it rises higher. This treatment was used by the author in many cases of pneumonia of the severest type, and with strikingly favorable results. In not a single case has the author noticed any collapse or any other untoward symptoms following this treatment. He considers the weakening and depressing action which the untreated fever exerts on the heart much more dangerous and ruinous than the effects of the antipyretic. Antifebrin, in combination with pure opium, acted much less favorably than when in combination with Dover's powder.—*Merck's Archives.*

# INTERNAL MEDICINE AND NEUROLOGY.

UNDER THE CHARGE OF

J. ALLISON HODGES, A. M., M. D.,

PROFESSOR OF NERVOUS AND MENTAL DISEASES, UNIVERSITY COLLEGE OF MEDICINE, RICHMOND, VA.

WM. CLIFTON LYLE, M. D.,

INSTRUCTOR IN CHEMISTRY IN THE MEDICAL COLLEGE OF AUGUSTA, AUGUSTA, GA.

R. L. PAYNE, A. M., M. D.,

NORFOLK, VA.

PROLONGED FEVERS OF OBSCURE ORIGIN.—R. B. Preble, in the Journal of the American Medical Association of December 8, 1900, and in Medicine, January, 1901, says that both the malarial organism and that of tuberculosis may cause prolonged fevers of obscure origin because the localization of the organism is obscure, or as in the case of malaria when it occurs where the malarial parasite is not endemic. Recurrent fever occurs also in cases of pseudoleukemia. His paper, however, is limited to that group of cases which Leube calls "kryptogenetic sepsis." Sepsis is too commonly considered within the province of the surgeon, whereas the serious forms of sepsis are more common in medical practice. A concise definition of sepsis, septicemia, and septic pyemia is difficult. By these terms is understood the infection and intoxication of the organism as a whole, by one of a large number of bacteria and their chemical products. They are characterized by an irregular clinical course, and the infection atrium is unknown during life and often undiscovered after death.

Owing to the varying type of micro-organism, the different resistance of patients, and the liability of the infection to involve separate organs or groups of organs, the clinical manifestations are very difficult of classification. A convenient division is to recognize two main groups: (1) The systemic group, in which the organism as a whole suffers; (2) the focal group, in which some organ or set of organs furnishes the bulk of clinical symptoms. The latter division may be conveniently divided into (*a*) cardiac cases; (*b*) pulmonary cases; (*c*) gastro-intestinal cases; (*d*) hepatic cases; (*e*) renal cases; (*f*) osteal cases and articular cases; (*g*) dermal cases; (*h*) hematolytic cases; (*i*) nervous cases.

In the systemic type the onset may be gradual, resembling that of typhoid with depression. Usually the onset is sharp, with single or repeated chills, and the disturbance common to acute fevers. The temperature is often very irregular, but it may have a typhoid range or may be intermittent like that of malaria. The pulse is usually rapid before the temperature, and there is as a rule much depression and weakness from the beginning. Physical examination is generally negative, excepting an enlarged spleen such as is seen in most infectious diseases. There is a rapid reduction in hemoglobin and

the number of red corpuscles; the leucocytes may be increased, diminished, or normal in number. The Widal reaction is absent, and the diazo-reaction in the urine is frequently present and marked.

Diagnosis, while simple in surgical cases, is difficult in the absence of a distinct infection atrium. The diagnosis is based mainly upon exclusion of the typical infectious processes. A distinct advance has been made in the diagnosis of these infections of late years, as they were formerly classed under typhoid, malaria, etc. Repeated examinations of the blood, showing an absence of the malarial parasite, exclude that infection, and the absence of the Widal and diazo-reactions excludes typhoid fever.

Three Cases of Acromegaly.—At the meeting of the Chicago Neurological Society, held January 11th, Dr. Sydney Kuh reported three cases of acromegaly treated with pituitary bodies. In the first case the existing headache and mental depression seemed somewhat relieved, while in the other two cases the patients were benefited to a more marked degree; headache, vertigo, general weakness, hyperidrosis and projectile vomiting ceased, and in one instance trophic disturbances in the nails of the hands showed well-marked changes for the better. In the third case cramps in the calves of the legs appeared after the patient had been under treatment for nearly one and a half years and the woman became very much depressed mentally. The essayist said that he did not believe the results to be due to suggestion only. He believes that the disease of the pitutary body is the cause of acromegaly. In every case of this malady in which a thorough post-mortem examination was made, the gland was found to be affected not only in man, but also in the one case known to have occurred in an animal. There is a good deal of evidence to show that the hypophysis exerts some influence upon our physical development, that it may not only cause acromegaly, but under certain conditions the opposite condition, stunted growth.

Alteration in the Secretory Function of the Salivary Gland.—*First Article: Experimental Rabies.* By Dr. E. Zardo, in N. Y. Med. Jour.—The author has studied the changes which take place in the process of salivary secretion and in the salivary glands of animals which have been inoculated experimentally with rabies. His conclusions are as follows: In the normal salivary gland there are probably two processes which constitute secretion. The first of these is the formation of liquid substances which results in the development of vacuoles in the gland cells; the second is the emission of solid particles which consist of fragments of plotoplasm and cell nuclei. During the first few days after inoculation, the last of these processes is suspended, but it is intensified again later. The first, however, grows steadily more intense, so that the watery constituents of the saliva assume a greater and greater proportion, until, in the advanced stage, there is a veritable dropsy of the glandu-

lar cells. To this change, which is the result of a disturbance of the metabolism of the liquids in the cytoplasm, are due the alterations which are observed in these glands in animals inoculated with rabies. These changes may be summed up as follows: Swelling of the nuclei, indicating distubances in the osmotic equilibrium of the nucleus and the cytoplasm, so that the concentration of liquids is less in the cytoplasm; karyorrhexis, indicating that the intranuclear osmotic pressure increases to such a degree as to overcome the resistance of the nuclear membrane; the disappearance of the chromatin, which, according to Arnheim, takes place when currents of liquid pass through altered nuclei; the presence of remains of the chromatin filaments which do not disappear entirely. The common observation that there is an increased salivary secretion in experimental rabies is therefore confirmed by histologic demonstration. It remains to establish the relation of the virus of rabies to this anomaly of secretion. But, first, we must know how salivary secretion behaves in the presence of chemical stimuli, such as pilocarpine, atropine, etc., or of physical stimuli, such as electricity. The author expects to report further results of his work in this field in the near future.

Notes and Statistics Concerning the Treatment of Bubonic Plague in India.—By Dr. A. Lustig and Dr. G. Galeotti, in N. Y. Med. Jour.—This article is particularly interesting, as Lustig's serum is one of the preparations used in the struggle against bubonic plague in India. In summing up a review of the results of the prophylactic and curative administration of Lustig's serum, the authors say that this serum is the only preparation that has given satisfactory results, as proved by the experience of the health department of Bombay during the past four years. At present it is the only serum which is prepared in a special laboratory in Bombay (Parel Laboratory), and is widely used there both in hospital and private practice, while the other plague serums are practically abandoned. The sanitary authorities of Bombay are about to issue an official report which will give in detail the evidence concerning the value of Lustig's serum.

The Role of the Spleen in the Formation of Trypsin of the Pancreas. By Dr. A. A. Gertzen, in N. Y. Med. Jour.—The author reviews the evidences obtained by experiments on animals by Schiff, Gertzen, and Pachon, showing that the secretion of trypsin is dependant upon the condition of the spleen. In an article published in *Vratch* a year ago, Popelsky gave an account of his experiments which were intended to prove the opposite. The author says that Popelsky's experiments do not affect the value of the researches of the other observers named above, as in his investigations Popelsky did not keep within the conditions of the question itself. The authors who maintain that there is a connection between the spleen and the secretion of trypsin have

stated that this connection can only be observed during the act of digestion. The observations of Popelsky, however, were carried on before meals. Such experiments can only be compared to the attempts of a man to observe an eclipse an hour before the announced time, and who then declares that the astronomers were wrong. The facts upon which the assertions of the author and of Schiff and Pachon are based are as follows: The quantity of trypsin in pancreatic juice or in an infusion of the pancreas is proportionate to the swelling of the spleen, *i. e.*, the maximum amount of trypsin coincides with the maximum swelling of the spleen, while the minimum, which may equal zero, corresponds to the contracted condition of the spleen. In dogs and cats that receive food only once daily, the swelling of the spleen and the rapid rise in the amount of trypsin in the pancreactic juice begin simultaneously during the fifth hour after ingestion, reach their maximum during the seventh hour, and gradually subside. In animals deprived of the spleen there is no such rise of the amount of trypsin, but a total disappearance of this ferment from the pancreactic juice. If an infusion of splenic substance is added to a solution of protrypsin, obtained by extracting the pancreas of a starving animal, a very active ferment is at once obtained. The same result is obtained by the addition of venous blood flowing from the swollen spleen to the solution of protrypsin. If a dog deprived of its spleen is also deprived of one-half the pancreas, and if an aqueous extract of the swollen spleen is injected, and after twenty minutes the second half of the pancreas is removed, the extract obtained from this portion of the gland will digest albumin, while that obtained from the first half will be inactive.

Successful Removal of an Enlarged and Displaced Spleen.—By D'Arcy Power, F.R.C.S. The author reports the case of a woman, aged 43 years, who suffered from an abdominal tumor which was thought to be ovarian. Upon opening the abdomen the tumor was found to be an enlarged spleen. It was easily delivered from the abdominal cavity, measured eight inches in length, and weighed two pounds and a half when full of blood. The pedicle was very long, and tension upon it caused signs of collapse on the part of the patient. The pedicle was ligated and cut, and the abdominal wound closed, the patient making a good recovery. The blood examination, eight days after the operation, showed a moderate secondary anemia, with a leucocytosis of 17,000 per cubic millimeter. The various forms of leucocytes were present in their normal relative proportions. Splenectomy is a successful operation where the enlargement is not leucocythemic. The enlargement was probably due to elongation of the pedicle leading to alterations in the vascular supply and causing chronic congestion of the spleen ending in hypertrophy.—*British Med. Jour.*, Nov. 17, 1900.—*Advance in Surgery.*

# GENERAL ORTHOPÆDIAC AND GENITO-URINARY SURGERY.

UNDER THE CHARGE OF

WM. H. DOUGHTY, JR., A. B., M. D.

PROFESSOR OF ANATOMY AND CLINICAL SURGERY, MEDICAL DEPARTMENT UNIVERSITY OF GEORGIA, AUGUSTA, GA.

HUGH M. TAYLOR, M. D.

PROFESSOR OF SURGERY IN THE UNIVERSITY COLLEGE OF MEDICINE, RICHMOND, VA.

WILLIS F. WESTMORELAND, M. D.

PROFESSOR OF SURGERY IN THE ATLANTA COLLEGE OF PHYSICIANS AND SURGEONS, ATLANTA, GA.

REDUCTION OF HUMP IN POTT'S DISEASE.—By Dr. Phocas (Nord Medical, Lille, Oct. 1 and 15; Jour. Am. Med. Assoc., Dec. 1, 1900). In certain exceptional cases, in which the hump is dorsal or dorso-lumbar and of recent development, without an abscess or much alteration of the general health, or when there is paraplegia, extension under chloroform with very slight digital pressure may succeed in reducing the hump. The family should be warned of the dangers, and the method should be appreciated at its true value. This cautious and rare procedure is all that remains of the famous forcible reduction of the hump vaunted by Calot. Even with this apparently harmless procedure, Dr. Phocas had the following experience: A girl of thirteen, with right torticollis, painful on the slightest movement, had a severe attack of la grippe ten months previously. A cervical arthritis was diagnosed and the head gently straightened under chloroform and an apparatus applied. The manipulations were all extremely gentle, but the child was completely paralyzed the next day and died the day after. The autopsy showed Pott's disease. All the ligaments had been destroyed, and the spinal cord had been held erect only by the immobilization of the bones by the muscles. The moment that this immobilization ceased, the bones slipped and crushed the cord. Two other patients died from meningitis seven and three months after intervention, a total of three deaths in the twenty cases in which reduction was done. The hump has recurred in all of the seven reduced according to Calot's directions. The results have been satisfactory in only one of the twenty cases, although in three the hump was more or less diminished, and recurred lower down in another. In one case, paralysis appeared six months after a gentle reduction.

HIP-JOINT AMPUTATION, WITH PRESENTATION OF THE CASE.—By E. M. Gilliam, M. D. (in Columbus Med. Jour.), reports the following case: This young lad, who is eight years of age, lives in Corning, O. The latter part of September he fell from a walnut tree, a distance of about twenty feet, sustaining a compound comminuted fracture of the upper and middle thirds of the left femur.

The parts were badly infected when he entered St. Anthony's Hospital, Oct. 27, and general infection also existed. Tongue dry and brown; repeated chills; temperature 103-104, and pulse ranging from 140 to 150.

October 29 I made an explorative incision and evacuated nearly a pint of foul pus. The fragments of bone were greatly displaced; the medullary substance completely broken down and the periostium destroyed for a distance of over five inches; the muscular structures were also greatly disorganized.

To give him the best chance for his life I decided to amputate the hipjoint.

Wednesday morning, Oct. 31, he was prepared for operation and an hypodermic injection of morphia, $\frac{1}{4}$ gr. and atropia 1-100 gr. was given. Fifteen minutes after the injection, he was chloroformed and the "Wyeth's Bloodless Method" used. In this method the parts are transfixed by means of large mattress pins as follows: One of the needles or pins is introduced one inch below and slightly to the inner side of the anterior superior spinous process of the ilium and caused to transfix the tissues and emerge on the same level three inches external to the point of entrance. The other pin is introduced about one inch below the level of the croutch and just internal to the saphenous opening, transfixing the parts and emerging about one inch below the tuber ischii. A strong piece of rubber tubing is then thrown around the hip just above the pins to control hemorrhage. The amputation was then commenced and completed in forty-five minutes. There was practically no hemorrhage and but little shock.

The head of the femur was very difficult to disarticulate.

He rallied quickly and with the exception of some sloughing convalesced nicely. He is, as you will notice, in very good condition and will return to his home to-morrow.

I have in my hands the head, neck and portion of the shaft of the femur removed.

You perceive that the epiphysis and trochanters are detached from the head of the bone.

This was done while endeavoring to disarticulate the head from the acetabulum.

I will say that the infection extended to the acetabulum, some pus being liberated on disengaging the head of the bone.

Hepatectomy for Echinococcus Cyst.—R. S. Fowler reported to the Brooklyn Surgical Society (Brooklyn Medical Journal, January, 1901; Medicine, March, 1901), the case of an Italian woman 28 years of age who came to this country three years ago. With trifling exceptions she had enjoyed good health until three months before coming under observation, when she noticed a gradually increasing dragging pain in the left side. Soon after she discovered a tumor in the region of the umbilicus, which was tender and mov-

able. There was no rapid increase in size, but the pain, which was not constant at first, became continuous and more severe. The tumor was freely movable and apparently had no connection with the uterus or its appendages. The liver was of normal size and in normal position. The colon could be traced throughout its entire course, the one peculiarity being the transverse portion seemed a little higher than normal. There was no dullness in any part of the abdominal cavity. The right kidney was larger than normal and normally situated. The left kidney could not be palpated in any position of the body. The tumor was the size of two fists, and in front of it lay the transverse colon. It was small in its lower part, elastic to the feel, and its upper part solid. It felt and acted like a floating cystic kidney. Malignant disease was excluded, as there was no loss of weight or strength. The tumor could not be traced to the liver in the neighborhood of the gall-bladder, and it did not perceptibly move with respiration. It was noted that the colon moved with the tumor. A provisional diagnosis of floating cystic kidney was made upon the following facts: The tumor did not move with respiration; it was of the size and shape of a cystic kidney; the colon was in front of it; it was freely movable to all parts of the abdominal cavity; and the left kidney could not be palpated in any position of the body.

A four-inch median incision was carried through the abdominal wall and the peritoneal cavity opened. The colon presented in the incision and was pushed downward, this exposing the tumor and also the left lobe of the liver. It was then apparent that the trouble was an echinococcus cyst of the under surface of the left lobe of the liver, which had dragged the left lobe downward, causing a partially floating liver. The lower rounded portion of the cyst had become adherent to the anterior layer of the lesser omentum and to the colon in such a manner as to cause the colon to overlie it. The adhesions were easily separated and the tumor brought out of the abdomen. Its attachments to the liver were approximately six by two inches. The liver substance was cut through with a thermocautery and the cyst removed entire without rupturing. One point on the liver surface bled rather profusely, probably due to a severing of one of the larger branches of the portal vein. A suture served to arrest this hemorrhage, and the wound in the liver was packed with gauze. The round ligament was shortened and stitched to the abdominal wall with catgut, thus fixing the liver in its proper place. Gauze was packed between the liver and the diaphragm to support the organ and produce adhesions. Half of the packing was removed on the second day and the remainder one day later. The patient was discharged with a small sinus, which soon closed completely.

Lymphatic and Portal Infections Following Appendicitis.—J. C. Monroe (in the Therapeutic Gazette of Jan. 15, 1901; Medicine, March, 1901) says that infection of the retroperitoneal glands and

lymphatics, as well as the portal vein, is of great importance, and its early recognition by the general practitioner is necessary, that operative intervention may be undertaken. He believes that it is a condition much more frequent than is generally believed. These cases furnish the perirenal abscess and the sinuses in the loin or in the groin. If the process stops short of abscess formation, the patient may become a chronic invalid.

The diagnosis of portal phlebitis is not difficult post mortem, but it is an involved clinical problem. The writer is quite confident that infection of these structures is more common than is generally believed. When a case in which good drainage has been secured is progressing well, but with a persistent elevation of temperature, he at once thinks of this complication if involvement of the chest, kidneys, and pelvic organs excluded. Portal infection, when it reaches the degree of tenderness, jaundice, and general malaise, while it may be recovered from without usually calls for operation. Every case in which there is hepatic tenderness and a septic patient, whether attended with jaundice or not, is a possible portal phlebitis. The retroperitoneal lymphatics are probably always infected to some extent in inflammation of the appendix. The degree of the inflammation is not necessarily dependent on the extent of the inflammation, a mild chronic case at times giving rise to severe lymphangitis. The lymphatic disturbance may date its origin from an appendicitis occurring many months before. A lymphatic infection severe enough to warrant local treatment is rare in appendicitis, but is probably more common than portal infection. Occasionally, mild infections both of the lymphatics and of the portal system yield to medical treatment. Persistent fever, without other evident cause, should suggest one or both of these infections. Drainage in the loin gives prompt and satisfactory relief, even where pus or a diffuse cellulitis has formed. Prompt and thorough drainage of the liver, together with the removal of the inflamed appendix, offers the best means of recovery from septic infections of the liver. Aspiration of the liver is an imperfect procedure. Abdominal section with free exploration and free opening of all abscesses within reach is less dangerous and much more satisfactory.

The writer supports these conclusions by eight cases of lymphatic involvement after operations upon the appendix, and five cases of portal infection.

"The value of a thought cannot be told.
We live in deeds, not years; in thought, not breaths,
In feelings, not in figures on a dial.
We should count time by heart throbs. He most lives
Who thinks most—feels the noblest—acts the best."—*Bailey.*

# OBSTETRICS AND GYNÆCOLOGY.

UNDER THE CHARGE OF

J. W. LONG, M. D.,

EMERITUS PROFESSOR OF GYNÆCOLOGY, MEDICAL COLLEGE OF VIRGINIA, SALISBURY, N. C.

JOSEPH EVE ALLEN, M. D.,

PROFESSOR OF OBSTETRICS AND PEDIATRICS, MEDICAL DEPARTMENT UNIVERSITY OF GEORGIA AUGUSTA, GA.

WILLIAM S. GARDNER, M. D.,

INSTRUCTOR IN GYNÆCOLOGY IN THE COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE, M. D.

EDWARD NICHOLAS LIELL, M. D.,

JACKSONVILLE, FLA.

FORMERLY LECTURER GYNECOLOGY NEW YORK POLYCLINIC, AND VISITING GYNECOLOGIST ST. ELIZABETH HOSPITAL, NEW YORK.

OVARIAN GRAFTING.—R. T. Morris, in the Medical Record of January 19, 1901, says that ovarian grafting has its analogue in the grafting of portions of the thyroid gland, in which it has been necessary to remove that entire structure; no matter in what part of the body the graft is transplanted, it usually continues to perform its function. The cases of pregnancy which have occurred after double ovariotomy are due to the fact that a small portion of the ovary remains. In one of his cases in which he reopened the abdomen some months after a double tube operation, a small portion of the ovary on the distal side of the ligature was found to have retained its vitality. Such fragments of ovarian tissue have been thought to undergo absorption, but such is probably not the case. As early as 1895 he attempted the transplantation of ovarian tissue, in the hope that it would furnish the internal secretion of the ovary and thus avoid a precipitate menopause. His cases of ovarian grafting number twelve, of which six have been sufficiently well observed to admit of conclusions being drawn. In ovarian grafting he places the ovary that is to serve for a graft in physiological saline solution at a temperature of about 100°. In his early operations the graft was placed in a slit in the fundus of the uterus, but in later cases he has chosen the broad ligament as nearly as possible at the point that the ovary would normally occupy. By splitting the broad ligament and introducing the graft, it can be sutured in such a way that the inner surface of the ovary projects into the peritoneal cavity, while the right surface of the ovary is in contact with the denuded surface exposed by splitting the broad ligament. The result so far obtained in his experience is an avoidance of the menopause, the patients continuing to menstruate in a way that indicates that the grafts retain their vitality. In one of his cases pregnancy took place, but there was an early abortion. The result of operation upon animals is favorable to the contention that a grafted ovary will retain its vitality, will sustain menstruation, and in some cases which are exceptionally favorable may furnish a healthy ovum.—*Medicine.*

Fallacies Concerning the Menopause.—George Erety Shoemaker (Phil. Med. Jour., Jan, 12, 1901) says that this subject at the present day refers not only to imaginary evils attending the menopause, but to the almost fatalistic neglect of real diseases. For a long period in a woman's life, from thirty-five to sixty years of age, "change of life" is popularly supposed to cover every pelvic and abdominal symptom. The menopause is simply a period of readjustment, extending over a period of from one to three years, and should be accompanied by no more serious disorders than vasomotor disturbances and a few functional nerve symptoms.

The most dangerous fallacy is that severe and persistent hæmorrhage is but a symptom of the menopause and that time will cure it. Women too often allow an excessive flow to go on for a long time before becoming sufficiently alarmed to consult a physician. Methodical questions along the following lines must be asked in order to obtain satisfactory information: 1. What was the normal duration, interval and amount of menstruation in early life? 2. When was the normal flow increased? 3. Has the loss of blood been progressively increasing, taking the past few years and months as a measure? 4. Has cessation ever definitely occurred, and then after an interval has the flow been re-established? A normal period should not last more than five days, the interval should not be less than three weeks, and the amount passed daily should not be more than sufficient to moderately wet two to five napkins.

When the vaginal examination is to be made, let it be remembered that a normal cervix does not exclude cancer of the fundus. Three cases operated upon by the writer during the past year have shown well-marked carcinoma of the fundus uteri, yet the cervix, as seen through the speculum, appeared perfectly healthy.

Another fallacy is that with fibroid tumors of the uterus which are increasing in size or causing disturbances, it is well to wait patiently for the menopause to cure the patient. This idea arose when the mortality after fibroid hysterectomy was over 50 per cent. Now it is less than 6 per cent. in cases without heart or kidney lesions, and when hæmorrhage has not rendered the patient profoundly anæmic. While waiting fifteen or twenty years for the menopause to cure, they are subject to peritonitis, tubal degenerations, pressure on the various organs, degeneration of the heart muscle and invalidism from anæmia. Only small, uncomplicated tumors which do not grow or bleed can safely be left to await the coming of the menopause. Aside from all other dangers arising from fibromas, the possibility of malignant degeneration must always be considered when a policy of delay is advocated.—*Gyn. and Obstet. Jour.*

Tubal Gestation with Rupture in a Woman Previously Operated upon for Tubal Gestation with Missed Labor.—J. B. Lyth (The Lancet, November 17, 1900) says that one of the most frequent causes of sterility in women is an obstruction to the passage of the ovum along the Fallopian tube; where the obstruction is not com-

plete tubal gestation is most likely to occur, for the spermatozoon can pass through an opening too small to allow the passage of an ovum. The existence of long periods of sterility often occurs in connection with tubal pregnancy, and the history of the case reported corresponds in this respect with others noted. The patient's first child was born dead in 1882, in 1892 she had a history of a ten-months' pregnancy. The child apparently died at the ninth month but labor did not set in, therefore laparotomy was performed and a large full-grown dead child was removed. It lay in a cyst which was an expanded portion of the left broad ligament. She had no further pregnancy until the present year, when a series of irregular hæmorrhages viewed in the light of her previous experience led her to consider herself three months pregnant. Six weeks before admission to the hospital she had an attack of abdominal pain with collapse, nausea and jaundice. Several subsequent attacks of pain followed, and she was exsanguinated, with feeble pulse and subnormal tempeature. With stimulation she rallied and examination revealed a tumor on the right. The scar of the old incision was on the left. On opening the abdomen a mass of blood clot with placental tissue and a piece of umbilical cord four inches long came into view. The pregnancy was in the fimbriated end of right Fallopian tube, and had evidently advanced to the fifth month, but the fœtus was not found. The patient recovered.—*Gyn. and Obstet. Jour.*

Maternal Impressions.—Thomas J. T. McHattie and T. W. J. Allen (The Lancet, November 24, 1900) publish three cases bearing on the subject. Case first, when some months advanced in the pregnancy, saw an accident resulting in a gaping wound on the cheek of a child, extending from the angle of the jaw nearly to the mouth. In due time a child was born with a nævus on the cheek corresponding in position and direction to the wound above mentioned. Case second, when three months' pregnant, had a child run over by a bicycle, fracturing the lower end of the humerus. Six months later a healthy child was born with a so-called an intra-uterine amputation of the left forearm an inch below the elbow. Case third visited a "show" when three weeks' pregnant, and was impressed with the sight of various freaks. From that time until term she worried lest her child should be deformed. At term she was delivered of an anencephalous monster.—*Gyn. and Obstet. Jour.*

Placenta Prævia.—H. A. Giltner (Wisconsin Med. Recorder, Dec., 1900) was called at midnight to attend a patient in labor. The os was found but slightly dilated and the fœtus high in the pelvis. A little clotted blood had been passed in the evening, and soon after the physician's arrival about a pint of blood clot was passed. The pains ceased in about two hours, and not having returned five hours later, a hypodermic of morphia was given and the writer returned to his office. At noon he was summoned and found the child delivered with the placenta attached. There had been no hæmorrhage and

the uterus was well contracted. The peculiar feature of the case was that the placenta was expelled twenty minutes before the birth of the child. The child was dead, with the cord wrapped three times around the neck. Placenta Prævia was suspected when the first hæmorrhage took place, but as no further bleeding occurred during the succeeding seven hours, it was thought probable that there was no danger of such an accident, and that the patient was not really in labor, it being not full time. The patient made an uninterrupted recovery.—*Gyn. and Obstct. Jour.*

The Prevention and Relief of Post-Operative Intestinal Obstruction.—At the December meeting of the New York Practitioners' Society, an instructive paper on the foregoing subject was read by Dr. C. Cleveland. If at the end of the first twenty-four hours gas has passed from the bowel, the presumption of a favorable progress of the case is before the operator. Regarding the etiology of post-operative intestinal obstruction, the writer makes it clear in stating that, the peritoneum being a most sensitive membrane, any handling causes the excretion of plastic lymph. In abdominal operations for the removal of tumors or other diseased structures, the handling of intestines is likely to produce distortions and flexions, which become more and more fixed as time goes on by the plastic lymph thrown out. It is surprising how insignificant an adhesion may produce obstruction. The writer observed that in cases in which it was impossible, from one cause or another, to keep the intestines away from the field of operating and necessitating constant handling in order to proceed with the operation, there was always the greatest difficulty in effecting the passage of gas and fecal material. There are measures upon which the greatest reliance may be placed as factors in the prevention of undue intestinal handling: the instituting several days beforehand of the preparations for the operation, in the way of restricting diet, preparing the bowels by thorough evacuation, and above all, the use of the Trendelenburg position at the time of operation. It is necessary, as far as possible, to be particular to have no raw surface; to cauterize or cover with peritoneum every stump or particle of raw tissue. The use of decinormal salt solution in the abdominal cavity, or by intravenous infusion, is of decided value. Concerning the method of relief in obstruction, the writer has for a year or more been much interested in the insufflation of oxygen gas, designing to employ it always after abdominal section as soon as any symptoms of obstruction begin to manifest themselves. As a prophylactic measure it is of the highest importance. It should be introduced slowly, the patient always indicating the moment when it is desirable to stop. It not only has the power to straighten out the intestines and open the lumen for the passage of gas and fecal contents, but serves as a stimulus to peristalsis. To illustrate its use and its mechanical effect, the essential points in the histories of five cases of abominal section are recorded, four of the cases being desperate.—*Medical Record.*

E. N. L.

VENTROFIXATION.—X. O, Worder, in the *Annals of Gynecology and Pediatry* for October, 1899, reports five cases of firm ventrofixation followed by delivery at term. In two cases dystocia followed this operation, done for complete prolapse of the uterus with invasion of the vagina. One case terminated spontaneously; the other required Cæsarian section. The former case had been operated upon by himself, the latter by another surgeon. In both cases a series of operations was done at one sitting, including curettage, amputation of cervix, anterior colporrhaphy, ventrofixation, and perineorrhapy. In his own case very firm fixation of fundus and posterior wall of uterus to abdominal wall was made, in order to be sure of relieving prolapse. In the other case infection is said to have been the cause of broad attachment and firm fixation.

The author excludes from discussion other procedures intended to hold the uterus in anterior position, and defines the limits of ventro fixation as follows: It is the operation of preference in cases of complete prolapse of the pelvic organs and in cases in which a very large and heavy uterus, due to chronic metritis, is habitually retroverted or retroflexed and causes pronounced symptoms. In these cases he thinks less rigid fixation is ineffective. The fixation should be between the anterior uterine wall,not the fundus or posterior wall, and lower angle of wound. He attributes the serious after-results to errors in technique rather than to the procedure itself—*Medicine.*

EXSECTION OF THE OVARIES IN CONNECTION WITH THE REMOVAL OF DISEASED TUBES.—P. H. Harris (Ann. of Gyn. and Ped., Aug., 1900) in this paper addresses himself to all gynecologists, who by routine practice remove the ovary while exsecting or excising a diseased tube; to all who practice removal of both ovaries whilst exsecting both tubes; and especially to the much larger body of general practitioners who feel so particularly answerable for the condition of their patients after operation, when referring them to the surgeon. He lays special stress upon the fact that the Fallopian tubes, when once infected by suppuration, so persistently harbor it that they constitute the natural habitats of pelvic suppuration. The ovaries should be regarded as the contiguous and comparatively unwilling participants in these suppurations. The ovaries generally recover from the effects of inflammation when the adjacent and suppurating structures have been surgically or otherwise cured. He claims that the good results which have followed removal of the tubes and ovaries, for tubal suppurations, can in most cases be secured without sacrificing menstruation, thus preserving for such patients as much ovarian tissue, menstruation and consequent ovarian influence as possible, and not depriving them of the possibility of conception. He has observed one case of pregnancy following the removal of both tubes close to the uterus.—*Int. Med. Mag.*

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Considerable has been written on this subject which has all the respectabilty of ancient lineage. And like most other obsure things, has received no stint of authoritative attention.

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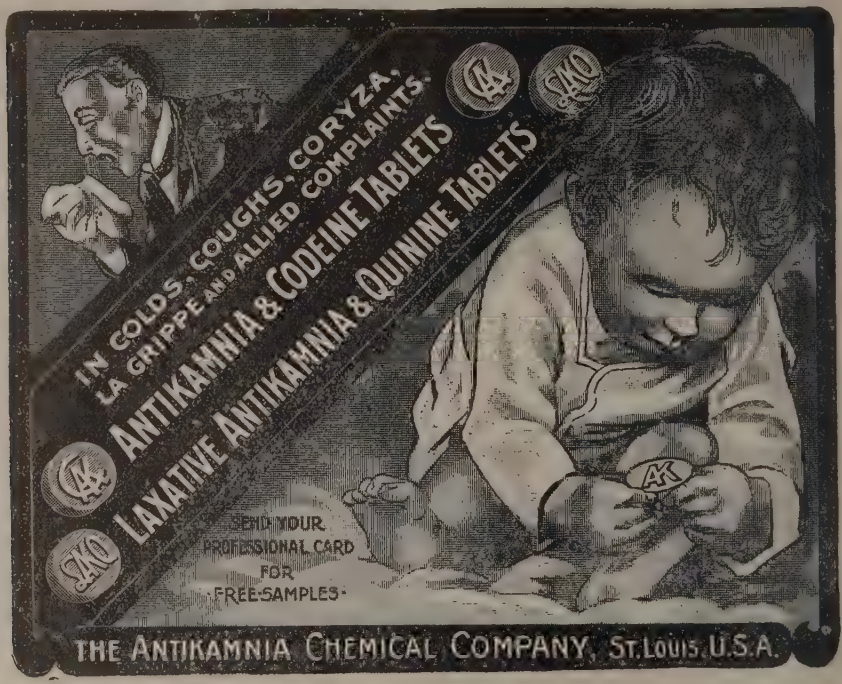
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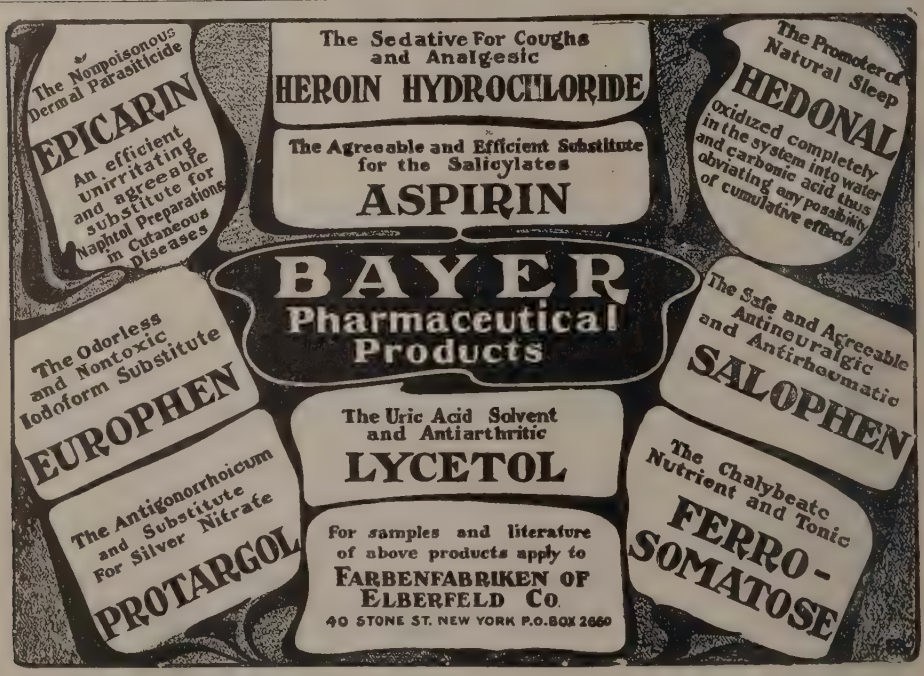
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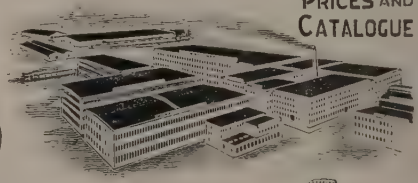

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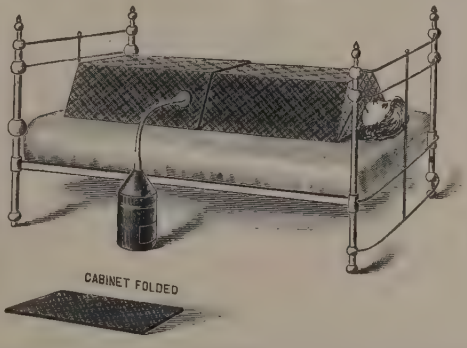

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